SERFF Tracking Number:	*RDWS-126450975*	*State:*	*Arkansas*
Filing Company:	*LifeShield National Insurance Co.*	*State Tracking Number:*	*45429*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*LifeShield LN-6040-AR Limited Benefit Cancer Expense*		
Project Name/Number:	*/*		

Filing at a Glance

Company: LifeShield National Insurance Co.

Product Name: LifeShield LN-6040-AR Limited Benefit Cancer Expense	SERFF Tr Num: RDWS-126450975	State: Arkansas
TOI: H07I Individual Health - Specified Disease - Limited Benefit	SERFF Status: Closed-Approved-Closed	State Tr Num: 45429
Sub-TOI: H07I.002A Dread Disease - Cancer Only	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Eddie Mire, Judy Tait	Disposition Date: 04/28/2010
	Date Submitted: 04/15/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 02/10/2010
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 04/28/2010	Explanation for Other Group Market Type:
	State Status Changed: 04/28/2010
Deemer Date:	Created By: Judy Tait
Submitted By: Judy Tait	Corresponding Filing Tracking Number:

Filing Description:

LifeShield National Insurance Co.

LN-6040-AR Limited Benefit Cancer Expense Policy

LN-6040amend-AR Limited Benefit Cancer Expense Policy Amendment

LN-6041-AR Annual Cancer Screening Benefit Rider

LN-6042-AR Daily Hospital Confinement Benefit Rider

LN-6043-AR First Occurrence Benefit Rider

SERFF Tracking Number:	*RDWS-126450975*	*State:*	*Arkansas*
Filing Company:	*LifeShield National Insurance Co.*	*State Tracking Number:*	*45429*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*LifeShield LN-6040-AR Limited Benefit Cancer Expense*		
Project Name/Number:	*/*		

LN-6044-AR First Occurrence Building Benefit Rider
LN-6045-AR Annual Radiation, Chemotherapy, Immunotherapy, & Experimental Treatment Benefit Rider
LN-6046-AR Daily Radiation, Chemotherapy, Immunotherapy, & Experimental Treatment Benefit Rider
LN-6047-AR Hospital Intensive Care Unit Benefit Rider
LN-6048-AR Surgical Benefits Rider
LN-6049-AR Payroll Application Form
LN-6050-AR Direct Application Form
LN-6051-AR Outline of Coverage
LN-6052-AR Specified Disease Benefit Rider

Company and Contact

Filing Contact Information

Judy Tait, Admin
Rudd and Wisdom, Inc.
9500 Arboretum Blvd
Suite 200
Austin, TX 78759

jtait@ruddwisdom.com
512-346-1590 [Phone]
512-345-7437 [FAX]

Filing Company Information

(This filing was made by a third party - ruddandwisdominc)

LifeShield National Insurance Co.
P. O. Box 1604
Duncan, OK 73534-1604
(800) 366-8354 ext. [Phone]

CoCode: 99724
Group Code:
Group Name:
FEIN Number: 73-1155182

State of Domicile: Oklahoma
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$700.00
Retaliatory?	No
Fee Explanation:	Arkansas required fee of $50 per form submitted
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
LifeShield National Insurance Co.	$700.00	04/15/2010	35678003

SERFF Tracking Number:	*RDWS-126450975*	*State:*	*Arkansas*
Filing Company:	*LifeShield National Insurance Co.*	*State Tracking Number:*	*45429*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*LifeShield LN-6040-AR Limited Benefit Cancer Expense*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/28/2010	04/28/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	04/19/2010	04/19/2010	Judy Tait	04/28/2010	04/28/2010

SERFF Tracking Number:	*RDWS-126450975*	*State:*	*Arkansas*
Filing Company:	*LifeShield National Insurance Co.*	*State Tracking Number:*	*45429*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*LifeShield LN-6040-AR Limited Benefit Cancer Expense*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 04/28/2010
Implementation Date:
Status: Approved-Closed
Comment:

Company Name:	**Overall % Indicated Change:**	**Overall % Rate Impact:**	**Written Premium Change for this Program:**	**# of Policy Holders Affected for this Program:**	**Written Premium for this Program:**	**Maximum % Change (where required):**	**Minimum % Change (where required):**
LifeShield National Insurance Co.	%	%	$		$	%	%

SERFF Tracking Number:	*RDWS-126450975*	*State:*	*Arkansas*
Filing Company:	*LifeShield National Insurance Co.*	*State Tracking Number:*	*45429*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*LifeShield LN-6040-AR Limited Benefit Cancer Expense*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document *(revised)*	Application	Approved-Closed	Yes
Supporting Document	Application	Replaced	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form *(revised)*	Limited Ben Cancer Expense Policy	Approved-Closed	Yes
Form	Limited Ben Cancer Expense Policy	Replaced	Yes
Form	Optional annual cancer screening ben rider	Approved-Closed	Yes
Form	Daily hospital confinement ben rider	Approved-Closed	Yes
Form	Optional first occurrence ben rider	Approved-Closed	Yes
Form	Optional first occurrence building ben rider	Approved-Closed	Yes
Form	Annual radiation, chemo, immunotherapy & experimental treatment ben rider	Approved-Closed	Yes
Form	Daily radiation, chemo, immunotherapy & experimental treatment ben rider	Approved-Closed	Yes
Form	Hospital intensive care unit ben rider	Approved-Closed	Yes
Form	Surgical Benefits Rider	Approved-Closed	Yes
Form	Specified disease benefit rider	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Rate	Rates	Approved-Closed	Yes

SERFF Tracking Number:	*RDWS-126450975*	*State:*	*Arkansas*
Filing Company:	*LifeShield National Insurance Co.*	*State Tracking Number:*	*45429*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*LifeShield LN-6040-AR Limited Benefit Cancer Expense*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	04/19/2010
Submitted Date	04/19/2010
Respond By Date	

Dear Judy Tait,

This will acknowledge receipt of the captioned filing.

Objection 1

- Limited Ben Cancer Expense Policy, LN-6040-AR (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

Objection 2

- Application (Supporting Document)

Comment:

All applications must contain a Fraud Statement as outlined under ACA 23-66-503 and Bulletin 7-97.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	04/28/2010
Submitted Date	04/28/2010

Dear Rosalind Minor,

Comments:
Thank you for your letter of April 19, 2010.

SERFF Tracking Number:	*RDWS-126450975*	*State:*	*Arkansas*
Filing Company:	*LifeShield National Insurance Co.*	*State Tracking Number:*	*45429*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*LifeShield LN-6040-AR Limited Benefit Cancer Expense*		
Project Name/Number:	*/*		

Response 1

Comments: We have made the change you requested on Page 14 under "Continuation of Coverage for Incapaciated Child."

Related Objection 1

Applies To:

- Limited Ben Cancer Expense Policy, LN-6040-AR (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Limited Ben Cancer Expense Policy	LN-6040-AR		Policy/Contract/Fraternal Certificate	Initial		45.000	LN-6040-AR.pdf
Previous Version							
Limited Ben Cancer Expense Policy	*LN-6040-AR*		*Policy/Contract/Fraternal Certificate*	*Initial*		*45.000*	LN-6040-AR.pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: We have added the required Fraud Statement to both applications.

Related Objection 1

Applies To:

- Application (Supporting Document)

SERFF Tracking Number:	*RDWS-126450975*	*State:*	*Arkansas*
Filing Company:	*LifeShield National Insurance Co.*	*State Tracking Number:*	*45429*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*LifeShield LN-6040-AR Limited Benefit Cancer Expense*		
Project Name/Number:	*/*		

Comment:

All applications must contain a Fraud Statement as outlined under ACA 23-66-503 and Bulletin 7-97.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Application

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

We look forward to hearing from you regarding this submission. Thank you for your assistance.

Sincerely,
Eddie Mire, Judy Tait

SERFF Tracking Number:	*RDWS-126450975*	*State:*	*Arkansas*
Filing Company:	*LifeShield National Insurance Co.*	*State Tracking Number:*	*45429*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*LifeShield LN-6040-AR Limited Benefit Cancer Expense*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: LN-6040-AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/28/2010	LN-6040-AR	Policy/Contract/Fraternal Certificate	Limited Ben Cancer Expense Policy	Initial		45.000	LN-6040-AR.pdf
Approved-Closed 04/28/2010	LN-6041-AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Optional annual cancer screening ben rider	Initial		45.000	LN-6041-AR.pdf
Approved-Closed 04/28/2010	LN-6042-AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Daily hospital confinement ben rider	Initial		45.000	LN-6042-AR.pdf
Approved-Closed 04/28/2010	LN-6043-AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorseme	Optional first occurrence ben rider	Initial		45.000	LN-6043-AR.pdf

SERFF Tracking Number:	*RDWS-126450975*		*State:*	*Arkansas*		
Filing Company:	*LifeShield National Insurance Co.*		*State Tracking Number:*	*45429*		
Company Tracking Number:						
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*		*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*		
Product Name:	*LifeShield LN-6040-AR Limited Benefit Cancer Expense*					
Project Name/Number:	*/*					
		nt or Rider				
Approved-Closed 04/28/2010	LN-6044-AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Optional first occurrence building ben rider	Initial	45.000	LN-6044-AR.pdf
Approved-Closed 04/28/2010	LN-6045-AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Annual radiation, chemo, immunotherapy & experimental treatment ben rider	Initial	45.000	LN-6045-AR.pdf
Approved-Closed 04/28/2010	LN-6046-AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Daily radiation, chemo, immunotherapy & experimental treatment ben rider	Initial	45.000	LN-6046-AR.pdf
Approved-Closed 04/28/2010	LN-6047-AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Hospital intensive care unit ben rider	Initial	45.000	LN-6047-AR.pdf

SERFF Tracking Number:	*RDWS-126450975*	*State:*	*Arkansas*	
Filing Company:	*LifeShield National Insurance Co.*	*State Tracking Number:*	*45429*	
Company Tracking Number:				
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*	
Product Name:	*LifeShield LN-6040-AR Limited Benefit Cancer Expense*			
Project Name/Number:	*/*			

Approved-Closed 04/28/2010	LN-6048-AR	Policy/Cont ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Surgical Benefits Rider	Initial	45.000	LN-6048-AR.pdf
Approved-Closed 04/28/2010	LN-6052-AR	Policy/Cont ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Specified disease benefit rider	Initial	45.000	LN-6052-AR.pdf
Approved-Closed 04/28/2010	LN-6040amend-AR	Policy/Cont ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Amendment	Initial	45.000	LN-6040-amend-AR.pdf

LifeShield National Insurance Company®

Administrative Office: 815 West Ash Ave., Duncan, OK 73533 Toll Free: 1-800-366-8354

LIMITED BENEFIT CANCER EXPENSE POLICY

This Policy offers Limited Benefit Supplemental Health Insurance Coverage.

GUARANTEED RENEWABLE FOR LIFE

Except for fraud or material misrepresentation, the Named Insured has the right to renew this Policy for his or her lifetime, as long as premiums are paid on time. This Policy will terminate on the last day of the period for which premium is paid unless continued in force during a Grace Period. We reserve the right to change premiums.

PREMIUMS SUBJECT TO CHANGE ON RENEWAL

On any premium due date after the first Policy Anniversary, We may change the premium rates for this policy only if We also change the rates for all other policies issued in the same Rating Class. We must give 60 days advance written notice of any premium change. No change in the premiums will be made because of the number of claims an Insured Person files nor because of a change in an Insured Person's health.

PART A. INSURING CLAUSE

LifeShield National Insurance Company (herein referred to as We, Us or Our) agrees with the Named Insured (herein referred to as You, or Your) to cover each Insured Person identified in the Policy and any attached riders, amendments, endorsements or applications for any covered loss described in this Policy in return for payment of premiums and subject to the provisions, limitations and exclusions that follow. This Policy is executed as of the Policy Effective Date as shown on the Schedule Page and from which anniversary dates are measured. This Policy takes effect at 12:01 A.M. Standard Time on the Policy Effective Date at the address of the Named Insured.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

The issuance of this Policy is based upon Your answers to the questions on the application. A copy of the application is attached to this Policy. If Your answers are materially incorrect or untrue, We may have the right to deny benefits or rescind this Policy, subject to the Time Limit on Certain Defenses provision. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, please contact Us at this address: 815 West Ash Ave., Duncan, OK 73533.

NOTICE OF 30-DAY RIGHT TO EXAMINE POLICY

Within thirty (30) days from receipt of this Policy, You may return it for any reason. If returned, this Policy is void. Any premiums paid on the Policy will be refunded. This Policy may be returned to Us or to the agent who sold this Policy.

THIS IS A LIMITED BENEFIT POLICY - READ IT CAREFULLY!
NO BENEFITS WILL BE PROVIDED DURING THE FIRST TWO YEARS IMMEDIATELY FOLLOWING THE POLICY EFFECTIVE DATE FOR ANY CLAIMS RESULTING FROM PRE-EXISTING CONDITIONS.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare please review the "Guide to Health Insurance for People with Medicare" which is available from the company.

This Policy is governed by the laws of the state in which it was issued and delivered.

Signed for Us on the Policy Date.

Secretary

President

TABLE OF CONTENTS

POLICY SCHEDULE

Named Insured:	[John Doe]	
Policy Number:	[1234567]	
Policy Effective Date:	[September 1, 2006]	
Coverage Type:	[Individual] [Single Parent] [Family]	
Premium Payment Class:	[Payroll] [Direct]	
Coverage	**Maximum Benefit Amount**	**Annual Premium**
Base Policy	Base Policy Benefits	$[XXX]
Benefit Provision Amendment		[Included in Base Policy]
Optional Benefit Riders		
Annual Cancer Screening Benefit Rider	[$25, $50, $75, $100, $125] Per Calendar Year	$[XXX]
First Occurrence Benefit Rider	[$500, $1,000, $1,500, $2,000, $2,500, $3,000, $3,500, $4,000, $4,500, $5,000, $5,500, $6,000, $6,500, $7,000, $7,500, $8,000, $8,500, $9,000, $9,500, $10,000] Lifetime Maximum	$[XXX]
Surgical Benefits Rider	[$500, $1,000, $1,500, $2,000, $2,500, $3,000, $3,500, $4,000, $4,500, $5,000, $5,500, $6,000, $6,500, $7,000, $7,500, $8,000, $8,500, $9,000, $9,500, $10,000] Per Schedule	$[XXX]
Daily Hospital Confinement Benefit Rider	[$100, $150, $200, $250, $300, $350, $400, $450, $500, $550, $600] Per Day	$[XXX]
Annual Radiation Treatment, Chemotherapy, Immunotherapy and Experimental Treatment Benefit Rider	[$2,500, $5,000, $7,500, $10,000, $12,500, $15,000, $17,500, $20,000] Per Calendar Year	$[XXX]
Daily Radiation Treatment, Chemotherapy, Immunotherapy and Experimental Treatment Benefit Rider	[$200, $300, $400, $500, $600, $700, $800, $900, $1,000] Per Day	$[XXX]
First Occurrence Building Benefit Rider	$100, $200, $300, $400, $500, $600] Per Year	$[XXX]
Hospital Intensive Care Unit Benefit Rider	[$100, $150, $200, $250 $300, $350 $400, $450, $500, $550, $600, $650, $700, $750, $800, $850, $900, $950, $1,000] Per Day	$[XXX]
Specified Disease Benefit Rider **Initial Hospitalization Benefit** **Hospital Confinement Benefit**	 $ 1,500 Per Calendar Year $ 300 per Day for 1st 30 days $ 600 per Day for 31 or more days of continuous confinement	$[XXX]
Premium Mode: [Monthly]	**Total Annual Premium Amount:** **Total Modal Premium Amount:**	$ $

PART B. DEFINITIONS

When We use the following words, this is what We mean:

"Actual Charge" means the amount actually paid by or on behalf of the Insured Person and accepted by a provider for services provided. The amount the Insured Person is legally required to pay the provider for the covered services would be considered the Actual Charge. The negotiated fee, if any, between a managed care organization including but not limited to a preferred provider organization or Medicare would be considered the Actual Charge.

"Age" means Age last birthday of an Insured Person.

"Ambulatory Surgical Center" means a facility, within the United States, primarily licensed to provide elective or Outpatient surgical care and discharges each patient within the same working day. An Outpatient surgical unit of a Hospital also meets this criteria.

"Applicant" means the person first named as applicant in the application for insurance under this Policy.

"Application" means that document, signed by You, containing Your answers to Our questions and Your representations, which We accepted in good faith as being true, complete and correct, to the best of Your knowledge and belief. Your Application is the basis upon which We issued this Policy and it is attached to and made a part of the Policy.

"Audiologist" means anyone, other than an Immediate Family Member, who is licensed and certified to provide therapy to the hearing impaired.

"Calendar Year" means a period of 12 consecutive months starting on January 1 and ending on December 31 of the same year.

"Cancer" means a disease manifested by the presence of a malignant tumor that is characterized by the uncontrolled growth and spread of malignant cells that invade tissue, blood or the lymphatic system. This includes leukemia, Hodgkin's Disease, lymphoma, carcinoma, sarcoma or malignant tumor. Cancer also means Cancer In Situ, a malignant tumor that is confined to the site of origin, the cells of which have not invaded surrounding tissue. Cancer does not include other conditions which may be considered precancerous, including but not limited to, leukoplakia, actinic keratosis, carcinoid, hyperplasia, polycythemia, nonmalignant melanoma, moles or similar disease or lesions.

Such Cancer must be positively diagnosed by a Physician certified by the American Board of Pathology or the Osteopathic Board of Pathology to practice Pathologic Anatomy; and such diagnosis is on the basis of microscopic examination of fixed tissue or preparations from the blood system (either during life or post mortem).

The diagnosis of Cancer must be based solely on the criteria of malignancy established by the American Board of Pathology. Clinical diagnosis of Cancer will be accepted as evidence that Cancer exists in a Covered Person when a pathological diagnosis cannot be made, provided such medical evidence substantially documents the diagnosis of Cancer and the Covered Person receives treatment for Cancer.

"Cancer Treatment Center" means a Chemotherapy Treatment Center or Radiation Treatment Center.

"Charity Hospital" means a Hospital which, in the absence of insurance, does not normally make a charge for its services.

"Chemotherapy" means a drug that: (a) it modifies, destroys, slows the growth, or prevents the spread or recurrence of Cancer cells; and (b) it is approved by the United States Food and Drug Administration to treat Cancer in humans.

"Chemotherapist" means a person who is licensed to administer Chemotherapy or Immunotherapy drugs in the State where such drugs are administered to the Insured Person.

"Chemotherapy Treatment Center" means a Clinic or Outpatient section of a Hospital specializing in the treatment of Cancer with Chemotherapy or Immunotherapy on an Outpatient basis. It must be licensed by the State in which it operates.

"Clinic" means a place operating under the applicable state law or licensing requirements where specialized medical treatment is given.

"Colony Stimulating Factor" means substances that stimulate the production of blood cells or platelets. They must be approved by the United States Food and Drug Administration for use in human Cancer patients being treated with Radiation Treatment, Chemotherapy, or Immunotherapyany. Colony Stimulating Factors include, but are not limited to, granulocyte colony stimulating factors and granulocyte-macrophage colony stimulating factors, erythropoietin, epoetin alfa, darbepoetin, filgrastim, pegfilgrastim and sargramostin.

"Common Carrier" means only the following: commercial airline, passenger train, or bus line between cities. It does not include: taxis, city bus lines, or private charter airplanes.

"Convalescent Care Facility" means an institution that:

(a) is legally operated to provide care and treatment to sick and injured persons at their expense;
(b) is primarily engaged in providing skilled care under the supervision of a Physician during a period of convalescence for sickness or injury;
(c) provides 24-hour nursing services by or under the supervision of Registered Nurses on duty or call; and
(d) maintains a medical record of each patient.

Convalescent Care Facility **does not mean** a home or facility that is used primarily for rest; or provides care and treatment for drug addicts, alcoholics or the mentally ill; or primarily provides custodial or educational care**.**

"Date of Diagnosis" means the later of:

(a) the day the tissue specimen is taken;
(b) the day the definitive diagnostic test is performed that confirms a positive diagnosis when preformed by a Pathologist; or
(c) the day the Positive Diagnosis of Cancer or one of the listed Specified Diseases is pronounced when a clinical diagnosis is made.

"Dependent" means any of the following persons:

1. Your lawful spouse; and
2. any unmarried child, stepchild or adopted child of Yours who has not attained the age of 25, and is:
   (a) under 25 years of age on the date of application; or
   (b) born after the date of application and any applicable additional premium is paid before the 32nd day after the child's birth; or
   (c) adopted by You or who becomes Your stepchild before that child's 25th birthday; and
3. A child for whom You are required to provide insurance under a medical support order or an order enforceable by a court; and
4. Any unmarried child of your child if such child is younger than 25 years of age and is dependent on you for federal income tax purposes at the time of application for coverage of the child.

If You are a party in a suit in which the adoption of the child is sought by You, that child will be deemed to be "adopted". Also, if You become a legal guardian of a foster child, that child will be treated as an adopted child so long as: You continue as the child's legal guardian; the child is living with You and is dependent upon You for support; and all other requirements of the policy are met.

"Divorce/Divorced" means annulment or the dissolution of marriage.

"Effective Date" means the date an individual Insured Person's coverage begins under the Policy and is the latest of: (1) the Policy Effective Date as shown on the schedule page; or (2) the date shown on the endorsement or amendment adding the Insured Person to coverage under the Policy.

"Eligible Family Member" means a person for whom You furnish satisfactory Evidence of Insurability who is either Your spouse or a dependent child.

"Evidence of Insurability" means a statement of a Proposed Insured's medical history which We will use to determine if he or she is approved for coverage. Evidence of Insurability will be provided at Your expense.

"Experimental Treatment" means chemotherapy, or immunotherapy drugs not yet approved by the United States Food and Drug Administration for the treatment of Cancer which are the subject of ongoing clinical studies sponsored and funded by the National Cancer Institute to determine their toxicity, safety, efficacy or their efficacy compared to standard means of treatment. Treatment must be received in the United States or its territories and administered by an Oncologist as defined in this Policy. The Oncologist must certify, to the best of his or her knowledge and belief, that no other treatment having United States Food and Drug Administration approval is superior to the proposed Experimental Treatment.

"Government Hospital" means a hospital operated by or for an agency of the United States Government.

"Home Health Care" means the care and treatment of an Insured Person at his or her place of residence. Home Health Care is provided only if hospitalization or confinement in a Convalescent Care Facility would otherwise have been required. A plan establishing the necessary Home Health Care Services must be approved in writing by the attending Physician. Home Health Care Services must be provided by an agency that meets the qualifications set out below.

"Home Health Care Agency" means entity licensed to provide Home Health Care Services under applicable state law, or, in the absence of such state law, an entity that meets the following requirements:

(a) it must be primarily engaged in providing Home Health Care Services;
(b) its policies must be established by a group of professional personnel, including at least one Physician and one Registered Nurse;
(c) supervision of Home Health Care Services must be performed by a Physician or Registered Nurse;
(d) it must maintain clinical records on all patients;
(e) it must have a full time administrator.

"Home Health Care Services" means:

(a) part-time or intermittent home nursing care provided by or under the supervision of a Registered Nurse;
(b) part-time or intermittent home health aide services that consists primarily of caring for the patient; and
(c) medical supplies and equipment suitable for home use.

Home Health Care Services **does NOT mean:** (a) services or supplies not included in the Home Health Care plan; (b) services of a person who is an Immediate Family Member; (c) custodial care; (d) services or supplies for personal comfort or convenience; (e) food service or meals; or (f) transportation services.

"**Hormonal Therapy"** means a drug that adds, blocks, or removes hormones to slow, stop the growth of or prevent the recurrence of Cancer cells. It must be approved by the United States Food and Drug Administration to treat Cancer in humans.

"Hospice Center" means a facility that provides short periods of confinement for terminally ill patients. A Hospice Center must operate a program of hospice care that meets the standards set forth by the National Hospice Organization. It must also be directed by a Physician, supervised by a Registered Nurse, and licensed or certified by the state in which it is located.

"Hospice Team" means a team of professionals including a Physician and a Nurse. It may also include a social worker, clergyman, clinical psychologist, physical therapist, or counselor. It must exist primarily to administer a hospice care program meeting the standards of the National Hospice Organization in the patient's home. Care must be available 24 hours a day, seven days a week.

"Hospital" means an institution that:

(a) operates as a Hospital pursuant to law;
(b) operates primarily for the reception, care and treatment of sick or injured persons as Inpatients;
(c) provides 24-hour nursing service by Registered Nurses on duty or on call;
(d) has a staff of one or more Physicians available at all times;
(e) provides organized facilities for diagnosis, treatment and surgery either on its premises or in facilities available to it on a pre-arranged basis.

Hospital **does NOT include** the following: (a) convalescent homes or convalescent, rest or nursing facilities; (b) facilities primarily affording custodial, educational or rehabilitative care; or (c) facilities for the aged, drug addicts or alcoholics.

"Immediate Family Member" means You and Your spouse or the parent, child, brother or sister of You or Your spouse.

"Immunoglobulin" means a protein naturally made by plasma cells in response to an antigen (foreign substance). The protein helps destroy the antigen. For the purposes of this Policy, the protein may be either natural or recombinant but it must be approved by the United States Food and Drug Administration for use in treating Cancer in humans.

"Immunotherapy" means a drug including a biological response modifier, biological therapy or biotherapy. that meets the following criteria: (1) it stimulates or restores the ability of the immune system to modify, destroy or aid in the prevention of the spread of Cancer cells and (2) it is approved by the United States Food and Drug Administration to treat Cancer in humans. Immunotherapy **does NOT include** Immunoglobulin.

"Incapacitated Child" means a Dependent child who becomes incapable of self-support because of physical impairment or mental retardation while an Insured Person and before attaining Age 25 and who is primarily dependent on You or Your spouse for support and maintenance and is unmarried.

"Inpatient" means the Insured Person who is confined in a Hospital using and being charged for daily room and board.

"Insured Person" means You and Your Eligible Family Members whose coverage has become effective and such coverage has not been terminated.

If the Type of Coverage shown on the Policy Schedule is **Individual**, Your Newborn Child or Your Newly Adopted Child will become an Insured Person for a period of 31 days commencing with the moment of birth or adoption. Thereafter the Newly Adopted Child or Newborn Child will be considered a Dependent child who is an Eligible Family Member and insurance will continue past this 31 days only if You give Us written notice of the birth or adoption within the 31 day period and pay the additional premium required.

If the Type of Coverage shown on the Policy Schedule is **Single Parent** or **Family**, Your Newborn Child or Your Newly Adopted Child will become an Insured Person commencing with the moment of birth or adoption. Thereafter the Newborn Child or Newly Adopted Child will be considered a Dependent child who is an Eligible Family Member.

"Internal Cancer" means Cancer that is not a Skin Cancer.

"Local or Locally" means within 30 miles, one way, of the Insured Person's usual place of residence.

"Named Insured" means the person accepted for coverage by Us who has completed and signed the application. This is the person whose name appears on the Policy Schedule as "Named Insured."

"Newborn Child" means any child born to You or Your insured Spouse after the Policy Effective Date.

"Newly Adopted Child" means a child who is: (a) adopted by You after the Policy Effective Date; or (b) a child who has been placed with You after the Policy Effective Date and for whom the application and approval procedures prescribed by law for adoption have been completed.

"Non-Local or Non-Locally" means more than 30 miles, one way, and less than 700 miles, one way, from the Insured Person's usual place of residence.

"Nurse" means any one of the following who is not one of the Insured Person's Immediate Family Members: a graduate Registered Nurse (R.N.); or a Licensed Practical Nurse (L.P.N.); or a Licensed Vocational Nurse (L.V.N.). With respect to the benefits provided under this Policy, Nurse will not include an R.N., L.P.N., or L.V.N. who is employed by the Hospital where the Insured Person is confined.

"Oncologist" means a Physician certified to practice in the field of Oncology.

"Outpatient" means the Insured Person is not confined in a Hospital.

"Pathologist" means a Physician who has been certified by either the American Board of Pathology, the Osteopathic Board of Pathology, or the American Board of Dermatopathology to practice pathological anatomy.

"Period of Hospital Confinement" means the period of consecutive days that the Insured Person is confined as an Inpatient in a Hospital on the advice and recommendation of a Physician. It begins on the date the Insured Person is admitted to the Hospital as an Inpatient and ends on the Insured Person's date of discharge, unless discharge is for the purpose of immediate readmission to another Hospital.

"Physician" means a practitioner of the healing arts, including a nurse practitioner, duly licensed, practicing in the United States and legally qualified to treat sickness or injuries. Such person must not be the Insured Person, an Insured Person's Immediate Family Member or a business associate. He or she must be providing services within the scope of his or her license, and must be a board certified specialist where required by this policy. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible Physicians.

"Policy Anniversary" means the same day and month as the Policy Effective Date shown in the Policy Schedule for each year this policy remains in force.

"Policy Effective Date" means the day on which coverage under the Policy begins and is shown on the Policy Schedule.

"Pre-existing Condition" means Cancer, or a listed Specified Disease if that optional rider is issued, which was diagnosed by a Physician or for which medical consultation, advice or treatment was recommended by or received from or sought from a Physician within five years prior to the effective date of coverage for each Insured Person.

"Proposed Insured" means any person named in Your application for insurance.

"Radiation Treatment" means x-ray therapy, gamma ray therapy, particle beam therapy, proton beam therapy, or intensity-modulated radiation therapy**,** brachytherapy, radioactive isotopes therapy, radioactive iodine, cobalt, palladium, cesium or iridium that is approved by the United States Food and Drug Administration for the treatment of Cancer in humans and is used to modify, destroy, slow the growth or prevent recurrence of Cancer cells. The treatments discussed above must not be used for diagnostic or planning purposes.

"Radiation Treatment Center" means a Clinic or outpatient section of a Hospital specializing in Radiation Treatment of Cancer on an Outpatient basis.

"Radiation Therapist" means a Physician, Nurse or other medical personnel who are licensed to administer external or internal radiation. The medical professional must also be certified by the American Board of Radiology to administer therapeutic radiation.

"Rating Class" means a population segment classified by actuaries as having similar insurance risk characteristics, such as issue age, gender, underwriting classification, benefit category, issue state, and health status of the insured at the time the policy was purchased.

"Renewal Date" means the date any premium after the first premium for this Policy is due.

"Skin Cancer" means basal cell carcinoma, basal cell epithelioma, squamous cell carcinoma, or melanoma of Clark's Level I or II or Breslow level equal to or less than 1.5 mm.

"Tentative Diagnosis" means a diagnosis by a qualified Physician, based on the Physician's experience, training and expertise, when a Positive Diagnosis cannot be made due to medical reasons**.**

"Terminally Ill" means the Insured Person has a life expectancy of 6 months or less.

"Total Disability / Totally Disabled" means that, as a result of Cancer, You are:

(a) unable to perform all of the substantial or material duties of Your regular occupation during the first two years beginning with the commencement of such disability;
(b) unable to engage in any employment or occupation for which You are or become qualified by reason of education, training or experience after the first two years beginning with the commencement of such disability; and
(c) under the care of a Physician.

If 60 days or less separate two periods of Total Disability for the same Cancer, the second will be a continuation of the first.

"We, Our, Us, or Company" means LifeShield National Insurance Company.

"You or Your" means the Named Insured.

PART C. BENEFIT PROVISIONS

We will pay the benefits as described in PART D for the treatment of an Insured Person's Cancer, and if such optional rider is also issued, for the treatment of a listed Specified Disease provided he or she is covered under this Policy and/or rider and this Policy and/or rider remains in force. Payment will be made in accordance with all applicable Policy and/or rider provisions. Benefits are payable for a positive diagnosis that begins more than 30 days after the Effective Date. The positive diagnosis must be for Cancer as defined in this Policy, or for a Specified Disease as defined in the optional rider.

All benefits are subject to terms and conditions of this Policy and/or Specified Disease rider. If Cancer or a listed Specified Disease is diagnosed while You or any Insured Person is confined in the Hospital, benefits will begin on the day of admission or 10 days prior to the date of diagnosis if this is more favorable to You. Admission to the Hospital must begin more than 30 days after the Effective Date of coverage. If a positive diagnosis is made for Cancer or a listed Specified Disease within 12 months after a Tentative Diagnosis, benefits will be paid from the date of the Tentative Diagnosis if the Tentative Diagnosis is made more than 30 days after the Effective Date of coverage**.**

PART D. DESCRIPTION OF BENEFITS

Positive Diagnosis Benefit - We will pay the Actual Charge not to exceed $300 per Calendar Year for one test that confirms the positive diagnosis of Cancer in an Insured Person. This benefit is not payable for multiple diagnoses of the same Cancer or for Cancer that metastasizes or for recurrence of the same Cancer.

National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation / Consultation Benefit - If an Insured Person receives a positive diagnosis of Internal Cancer and seeks an evaluation or consultation at a National Cancer Institute designated Comprehensive Cancer Treatment Center for the purpose of obtaining a treatment option opinion, We will pay the Actual Charge not to exceed a lifetime

maximum of $750. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the Insured Person's place of residence, We will also pay the transportation and lodging expenses incurred not to exceed a lifetime maximum of $350. This benefit is not payable on the same day a Second or Third Surgical Opinion Benefit is payable. This benefit is payable in lieu of the Non-Local Transportation and Lodging Expense Benefits of the Policy. This benefit is payable one time during the lifetime of the Insured Person.

Second and Third Surgical Opinion Expense Benefit – If surgery is recommended for the removal of Cancer, We will pay the Actual Charge for a written second surgical opinion concerning the Cancer surgery. If the second surgical opinion is in conflict with that of the Physician originally recommending the surgery, We will pay the Actual Charge for a written third surgical opinion. The Physician providing the second or third surgical opinion cannot be associated with the Physician who originally recommended the surgery. This benefit is not payable for the same day the National Cancer Institute Evaluation/Consulting Benefit is payable.

Outpatient Hospital or Ambulatory Surgical Center Expense Benefit - We will pay the Actual Charge, not to exceed $350 per day, made by an Ambulatory Surgical Center or Outpatient department of a Hospital for the use of its facilities during the performance of a surgical procedure covered under this Policy.

Medical Imaging, Treatment Planning and Monitoring Expense Benefit - We will pay the Actual Charge not to exceed $1,000 per Calendar Year, for laboratory tests, routine or diagnostic X-rays, scans or medical images and their interpretation when used in the planning or monitoring of external radiation, internal radiation, Chemotherapy or Immunotherapy treatments of Cancer.

Anti-Nausea Medication Expense Benefit - We will pay the Actual Charge for anti-nausea medication not to exceed $150 per Calendar Month when an Insured Person is prescribed such medication as the result of Radiation Treatment, Chemotherapy or Immunotherapy treatments for Cancer.

Colony Stimulating Factor or Immunoglobulin Expense Benefit - We will pay the Actual Charge not to exceed $1,000 per calendar month for Colony Stimulating Factor Drugs or Immunoglobulins prescribed by a Physician or Oncologist during an Insured Person's Cancer treatment regimen for which benefits are payable under the Radiation, Chemotherapy and Immunotherapy Benefit of this Policy or rider attached to it.

Outpatient Blood, Plasma and Platelets Expense Benefit - If, as the result of Cancer, an Insured Person requires blood, plasma, platelets or blood transfusions, on an Outpatient basis, We will pay the Actual Charge not to exceed $300 per day including the costs of procurement, administration, processing and cross matching.

Inpatient Blood, Plasma and Platelets Expense Benefit - If, as the result of Cancer, an Insured Person requires blood, plasma, platelets or blood transfusions, on an Inpatient basis, We will pay the Actual Charge not to exceed $300 per day including the costs of procurement, administration, processing and cross matching.

Bone Marrow Donor Expense Benefit - When an Insured Person receives bone marrow or stem cells from another live person for the purpose of a bone marrow or stem cell transplant in connection with the Insured Person's Internal Cancer treatment, We will pay the Daily Hospital Confinement Benefit amount shown on the Policy Schedule for each day the donor is confined in a Hospital for the harvesting of bone marrow or stem cells used in a covered bone marrow or stem cell transplant.

Bone Marrow or Stem Cell Transplant Expense Benefit - We will pay the Actual Charge not to exceed a lifetime maximum of $15,000 for surgical and anesthesia procedures (including the harvesting and subsequent re-infusion of blood cells or peripheral stem cells) performed for a bone marrow transplant and/or a peripheral stem cell transplant for the treatment of an Insured Person's Internal Cancer**.** This benefit will be paid in lieu of the Surgical Expense Benefit and the Anesthesia Expense Benefit which may be described in a rider attached to this policy.

Inpatient Oxygen Expense Benefit – When an Insured Person is confined to a Hospital for the treatment of Cancer and requires oxygen that is prescribed and ordered by a Physician, We will pay the Actual Charge for the oxygen not to exceed $300 per Hospital confinement.

Attending Physician Expense Benefit - We will pay the Actual Charge not to exceed $ 40 per day for the professional services of a Physician or Oncologist rendered to an Insured Person while he or she is confined in a Hospital for the treatment of Cancer. This benefit is payable only if the Physician or Oncologist personally visits the Hospital room occupied by the Insured Person. The benefit amount stated is the maximum amount payable for each day of Hospital confinement regardless of the number of visits made by one or more Physicians or Oncologists.

Inpatient Private Duty Nursing Expense Benefit - We will pay the Actual Charge not to exceed $150 per day for the full time service of a Nurse that is required and ordered by a Physician when an Insured Person is confined in a Hospital for the treatment of Cancer. The Nurse must provide services other than those normally provided by the Hospital. The Nurse may not be an employee of the Hospital or an Immediate Family Member of the Insured Person.

Outpatient Private Duty Nursing Expense Benefit – Following a period of Hospital confinement of an Insured Person for the treatment of Cancer, We will pay the Actual Charge not to exceed $ 150 per day, limited to the same number of days of the prior Hospital confinement, for the full time service of a Nurse that is required and ordered by a Physician when an Insured Person is confined indoors at home as the result of Cancer. This benefit is not payable if the services of the Nurse are custodial in nature or to assist the Insured Person in the activities of daily living. This benefit is not payable when the Nurse is a member of the Insured Person's Immediate Family.

Home Health Care Expense Benefit - We will pay benefits for the following covered charges when an Insured Person requires Home Health Care for the treatment of Cancer.

1. Home Health Care Visits - We will pay the Actual Charge for Home Health Care Visits not to exceed $ 75 for each day on which one or more such visits occur. We will not pay this benefit for more than 60 days in any Calendar Year.
2. Medicine and Supplies - We will pay the Actual Charge not to exceed $ 450 in any Calendar Year for drugs, medicine, and medical supplies provided by or on behalf of a Home Health Care Agency.
3. Services of a Nutritionist - We will pay the Actual Charge not to exceed a lifetime maximum of $ 300 for the services of a nutritionist to set up programs for special dietary needs.

Convalescent Care Facility Expense Benefit - We will pay the Actual Charge not to exceed $ 100 per day for an Insured Person's confinement in a Convalescent Care Facility. The maximum number of days for which this benefit is payable will be the number of days in the last Period of Hospital Confinement that immediately preceded admission to the Convalescent Care Facility. The Convalescent Care Facility confinement must:

1. be due to Cancer;
2. begin within 14 days after the Insured Person has been discharged from a Hospital for the treatment of Cancer; and
3. be authorized by a Physician as being medically necessary for the treatment of Cancer.

Hospice Care Expense Benefit – When an Insured Person, as a result of Cancer, requires Hospice Care, We will pay the Actual Charge for Hospice Care not to exceed $ 100 per day. This benefit is payable whether confinement is required in a Hospice Center or services are provided in the Insured Person's home by a Hospice Team. Eligibility for benefit payments will be based on the following conditions being met: (1) the Insured Person has been given a prognosis of being Terminally Ill with an estimated life expectancy of 6 months or less; and (2) We have received a written summary of such prognosis from the attending Physician. We will not pay this benefit while the Insured Person is confined to a Hospital or Convalescent Care Facility. The lifetime maximum benefit is 365 days of Hospice Care.

Non-Local Transportation Expense Benefit - We will pay the Actual Charge for Non-Local transportation not to exceed coach fare by on a Common Carrier for the Insured Person and one adult companion's travel to a Hospital, Radiation Therapy Treatment Center, Chemotherapy Treatment Center, Oncology Clinic or any other specialized treatment center where the Insured Person receives treatment for Cancer. This benefit is payable only if the treatment is not available Locally but is available Non-Locally. The adult companion may include the live donor of bone marrow or stem cells used in a bone marrow or stem cell transplant for the Insured Person. At the option of the Insured Person, We will pay a single private vehicle mileage allowance of 50 cents per mile for Non-Local transportation in lieu of the common carrier coach fare.

Lodging Expense Benefit - When an Insured Person receives treatment for Cancer at a Non-Local Hospital, Radiation Therapy Treatment Center, Chemotherapy Treatment Center, Oncology Clinic or any other specialized treatment center, We will pay the Actual Charge not to exceed $ 75 per day for a room in a motel, hotel or other appropriate lodging facility (other than a private residence). The room must be occupied by the Insured Person or an adult companion, which may include the live donor of bone marrow or stem cells used in a bone marrow or stem cell transplant for the Insured Person. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment, nor for lodging expense incurred more than 24 hours following treatment. This benefit is limited to 100 days per Calendar Year.

Ambulance Expense Benefit - We will pay the Actual Charge for ambulance service if an Insured Persons is transported to a Hospital where he or she is admitted as an Inpatient for the treatment of Cancer. The ambulance service must be provided by a licensed professional ambulance company or an ambulance owned by the Hospital.

Prosthesis Expense Benefit:
(a) Surgically Implanted Breast Prosthesis – If, as the result of breast removal due to Cancer, the attending Physician prescribes a breast prosthesis to restore normal body contour, We will pay the Actual Charge for the prosthesis and its implantation. This benefit does not include coverage for breast reconstruction surgery which may be covered under the Surgical Schedule within the Surgical and Anesthesia Benefits Rider, if such rider is issued as part of this policy.
(b) Non-Surgically Implanted Prosthesis – If an Insured Person sustains an amputation, as the result of treatment for Cancer, and an artificial limb or other non-surgically implanted prosthetic device is required and prescribed by a Physician to restore normal body function, We will pay the Actual Charge not to exceed a lifetime maximum of $ 2,000 per such amputation. The cost for the replacement of a prosthetic device is not covered. Hairpieces or wigs are not covered under this benefit.

Hairpiece Expense Benefit – If an Insured Person suffers hair loss due to Cancer treatments, We will pay the Actual Charge not to exceed a lifetime maximum of $150 for the purchase of a wig or hairpiece.

Rental or Purchase of Medical Equipment Expense Benefit – If, as the result of Cancer, the attending Physician prescribes covered medical equipment designed for home use, We will pay the lesser of the Actual Charge for the rental or purchase of such medical equipment not to exceed $1,500 per Calendar Year. Covered medical equipment includes wheel chair, oxygen equipment, respirator, braces, crutches or hospital bed.

Physical, Speech, Audio Therapy and Psychotherapy Expense Benefit - We will pay the Actual Charge not to exceed $ 25 per therapy session for:

1. Physical therapy treatments given by a licensed Physical Therapist, or
2. Speech therapy given by a licensed Speech Pathologist/Therapist; or
3. Audio therapy given by a licensed Audiologist; or
4. Psychotherapy given by a licensed Psychologist.

These therapy sessions may be given at an institute of physical medicine and rehabilitation, a Hospital, or the Insured Person's home. These treatments must be given on an Outpatient basis, unless the primary purpose of a Hospital confinement is for treatment of Cancer other than with physical, speech or audio therapy or psychotherapy. Benefits under this section may not exceed $1,000 per Calendar Year.

Waiver of Premium Benefit - We will waive the premiums starting on the first premium due date following a 60 day period of Total Disability of the Named Insured due to Cancer. The Named Insured must: (1) be receiving treatment for such Cancer for which benefits are payable under this Policy; and (2) remain disabled for 60 consecutive days. We will waive premiums for as long as the Named Insured remains Totally Disabled. Premiums will be waived in accordance with the mode of payment in effect when treatment began.

Totally Disabled means the Named Insured is:

(1) unable to work at any job for which he or she is qualified by education, training or experience; and
(2) under the care of a Physician for the treatment of internal Cancer.

If the Named Insured is retired or Age 65 and over at the time he or she becomes Totally Disabled, the definition of Total Disability will mean the inability to perform two (2) or more of the ADL's (Activities of Daily Living) listed below without the assistance of another person. ADL's are defined as activities used in measuring levels of personal functioning capacity. Normally, these activities are performed without assistance, allowing personal independence in everyday living. The ADL's are:

1. Transferring - moving between the bed and a chair or the bed and a wheelchair;
2. Dressing - putting on and taking off all necessary items of clothing;
3. Toileting - getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene;
4. Eating - all major tasks of getting food into the body;
5. Bathing - getting into or out of the tub or shower and otherwise washing the parts of the body.

We may ask for and use an independent consultant to determine whether the Named Insured can perform an ADL when this benefit is in force.

PART E. EXCLUSIONS AND LIMITATIONS

No benefits will be paid for

1. any loss due to any disease or illness other than Cancer;
2. care and treatment received outside the territorial limits of the United States;
3. treatment by any program engaged in research that does not meet the criteria for Experimental Treatment as defined;
4. treatment that has not been approved by a Physician as being medically necessary; or
5. losses or medical expenses incurred prior to the Effective Date of an Insured Person's coverage regardless of the Date of Positive Diagnosis.

Pre-Existing Condition(s) Limitation
The benefits of this policy will not be payable during the first 24 months that coverage is in force with respect to an Insured Person for a loss caused by a Pre-Existing Condition disclosed or not disclosed on the application. This 24-month period is measured from the effective date of coverage for each Insured Person.

PART F. PREMIUMS

Coverage is in consideration of and subject to payment of the first premium. An Insured Person’s first premium and premium payment mode is shown on the Policy Schedule. Subsequent premiums are due and payable on the premium due date.

Premium Payment Class - The Premium Payment Class for this Policy is shown on the Policy Schedule.

a. **Payroll** means that premiums for this Policy, on the Policy Effective Date, are withheld through payroll or share account deductions and remitted to Us by an employer or other third party.
b. **Direct** means premiums are remitted directly to Us by You through electronic funds transfer or by mail.

Grace Period - We grant a grace period of 31 days for each premium payment due after the first premium payment. Coverage remains in force during the grace period unless You have given Us written notice of Your request for cancellation.

Reinstatement - If the renewal premium is not paid before the Grace Period ends, the Policy will lapse. Later acceptance of the premium by Us without requiring an application for reinstatement will reinstate this Policy. If We require an application, the Named Insured will be given a receipt for the premium. If the application is approved, the Policy will be reinstated as of the approval date. Lacking that approval, the Policy will be reinstated on the 45th day after the date of the receipt unless We have previously written the Named Insured of its disapproval. The reinstated Policy will cover only loss that results from a covered disease that starts more than 10 days after the date of reinstatement. In all other respects, the Named Insured’s rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated Policy.

PART G. TYPES OF COVERAGE

The Type of Coverage issued is shown on the Policy Schedule.

1. **Individual** means that only the Named Insured shown on the Policy Schedule is covered.
2. **Single Parent** means that only the Named Insured and Dependent Child(ren) who is/are also Eligible Family Members are covered.
3. **Family** means that the Named Insured and all Eligible Family Members are covered.

PART H. TERMINATION OF COVERAGE

If We accept premium for coverage extending beyond the date, age, or event specified for termination of an Insured Person, then coverage of such person shall continue during the period for which such premium was accepted. This does not apply where such acceptance was based on a misstatement of age.

Individual Terminations - Your coverage under this Policy will terminate on the earliest of:

(a) the date of expiration of the Grace Period during which any premium due remains unpaid;
(b) the date You specify in Your written request for termination.

Any other Insured Person's coverage under this Policy will terminate on the earliest of:

(a) the date Your coverage terminates;
(b) the date he or she is no longer an Eligible Family Member;
(c) the date of expiration of the Grace Period during which any premium due for the Insured Person remains unpaid; or
(d) the date You specify in Your written request to terminate coverage for the Insured Person.

Time of Termination - Termination of coverage takes effect at 12:01 A.M. Standard Time at Your place of residence on the date of termination.

Pending Claims - Termination of coverage will not affect a claim for a covered loss that occurred while coverage was in force under this Policy.

Adjustment of Premium - If Your Coverage Type changes because of the termination of coverage of an Insured Person, and the change is to a type that has a lower premium, premiums becoming due following the date of change will be adjusted accordingly.

PART I. CONTINUATION OF COVERAGE

Continuation of Coverage for Incapacitated Child - An Incapacitated Child will continue as an Insured Person so long as he or she continues to meet the definition of an Incapacitated Child, any required premium is paid and You continue to be insured. We may request that You provide Us with a notice of incapacity. Regardless of the Incapacitated Child's age, he or she will continue to be charged the child's premium rate.

Continuation of Coverage If You Die - If You die, Your Spouse will replace You as the Named Insured. However, if Your Spouse is not an Insured Person at that time, coverage will end for all Insured Persons.

PART J. CONVERSION

Divorced Spouse Conversion - If the spouse's coverage under this Policy would terminate because of his or her divorce from the Named Insured, We agree to issue a new Policy to the spouse. The spouse must request the new policy and pay the required premium within 60 days of the divorce. Other dependents covered under this Policy may be covered under the new policy or under this Policy as the Named Insured and his or her spouse elect. They may not be covered under both policies. If either this Policy or a new policy is in force on the Named Insured or his or her divorced spouse and either remarries, such new spouse may be covered under the

appropriate policy. We must be advised of the remarriage by the completion of a new Application for the new spouse. This new Application is subject to Evidence of Insurability satisfactory to Us.

Child Conversion - A Dependent Child who is no longer an Eligible Family member due to marriage or the loss of Dependent status and who desires to continue coverage as a Named Insured under separate coverage may do so by notifying Us of the request in writing. The child will have the right to continue coverage as the Named Insured with separate similar coverage without Evidence of Insurability and with no interruption in coverage provided We receive written notification of the request prior to sixty (60) days after the marriage or the loss of dependent status.

PART K. HOW TO FILE A CLAIM

Notice of Claim - Written notice of claim must be received by Us within 30 days after an Insured Person's loss, or as soon thereafter as reasonably possible. Written notice given by or on behalf of the claimant to Us with information sufficient to identify the Insured Person, is deemed notice to Us. The written notice should include the Insured Person's name and the Policy number.

Claim Forms - When We receive the notice of claim, We will send the claimant forms for filing proof of loss. If these forms are not sent to the claimant within 15 days, the claimant will be deemed to have met the proof of loss requirement by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

Proof of Loss - We must receive written proof of loss within 90 days after it occurs or as soon thereafter as reasonably possible. Proof of loss includes any documentation necessary to establish that a benefit is payable. Proof of loss also includes, but is not limited to, explanation of benefits from other coverage of the Insured Person, if any, and any other documentation necessary to determine Actual Charges. Proof of loss would also include documentation showing the amount the Insured Person is legally required to pay the provider for the covered treatments. Proof provided more than one year late will not be accepted, unless the Insured Person had no legal capacity in that year.

PART L. TIME OF PAYMENT OF CLAIMS

All benefits payable under this policy for any loss, other than loss for which this policy provides any periodic payment, will be paid within thirty-five (35) days after receipt of due written proof of such loss in the form of clean claim.

Benefits due under the policy and claims are overdue if not paid within thirty-five (35) days after We receive a clean claim containing necessary medical information and other information essential for Us to administer preexisting conditions and determine Actual Charges.

A **"clean claim"** means a claim We receive for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the insured in order to be processed and paid by Us. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. A clean claim does not include any of the following:

(a) A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;
(b) Claims which are submitted fraudulently or that are based upon material misrepresentations;
(c) Claims that require information essential for Us to administer preexisting conditions or determine Actual Charges; or
(d) Claims submitted by a provider more than thirty (30) days after the date of service; if the provider does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the insured.

Not later than thirty-five (35) days after the date We receive a claim, We shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider or the insured of the reasons why the claim or

portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by Us shall be paid within twenty (20) days after receipt.

PART M. PAYMENT OF CLAIMS

Upon receipt of due written proof of loss, payments for all losses will be made to the Named Insured. If the Named Insured dies before all payments due have been made, the amount still payable will be paid to the Named Insured's estate.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding $1,000 per month may be made, at Our option, to any relative by blood or connection by marriage of the payee, who has submitted reliable documentary evidence and, in Our opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs. Any payment We make in good faith fully discharges Our liability to the extent of the payment made.

If the Named Insured provides Us with a written release to do so, we may, at Our option, pay benefits directly to the institution or person rendering treatment or services covered under this Policy.

Unpaid Premium- When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

PART N. GENERAL PROVISIONS

Entire Contract; Changes - This Policy, the Application, and any attached riders or amendments make up the entire contract. A copy of the Application is attached. In the absence of fraud, all statements made on the Application will be considered representations and not warranties. No written statement made by the Named Insured will be used in any contest unless a copy of the statement is furnished to the Named Insured or his or her personal representative. No change in this Policy will be valid until approved by an officer of the Company. The change must be signed by an officer of the Company and attached to this Policy. No agent may change this Policy or waive any of its provisions. .

Time Limit on Certain Defenses- After two years from the date a person becomes insured under this Policy, We cannot use misstatements, except fraudulent misstatements, in the Application to void coverage or deny a claim for loss that happens after the two-year period.

No claim for loss incurred after two years from the date a person becomes insured under this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description existed prior to the effective date of such person's insurance.

Physical Examination - We, at Our own expense, have the right to have the person of any individual whose loss is the basis of claim under this Policy examined when and as often as We may reasonably require during the pendency of the claim.

Legal Actions - No action at law or in equity may be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Noncompliance with Policy Requirements - Any express waiver by Us of any requirements of this Policy will not constitute a continuing waiver of such requirements. Any failure by Us to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

Conformity with State Statutes - Any provision of this Policy which, on its Policy Effective Date, is in conflict with the statutes of the state in which this Policy is issued and delivered is hereby amended to conform to the

minimum requirements of those statutes.

Clerical Error - Clerical error, whether by You or Us, will not void the insurance of any Insured Person if that insurance would otherwise have been in effect or extend the insurance of any Insured Person if that insurance would otherwise have ended or been reduced as provided in this Policy.

Assignment - You may assign all of Your rights, privileges and benefits under this Policy to the institution or person rendering the service as allowed in the Payment of Claims provision. We are not bound by an assignment until We receive and file a copy of the assignment containing the Named Insured's signature. We are not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of this Policy.

Misstatement of Age - If premiums for the Insured Person are based on age and the Insured Person's age has been misstated, there will be a fair adjustment of premiums based on his or her true age. If the benefits for which the Insured Person is insured are based on age and the Insured Person's age has been misstated, there will be an adjustment of said benefit based on his or her true age. We may require satisfactory proof of age before paying any claim.

Termination of an Insured Person - Upon the termination of coverage of an Insured Person, the premium on this Policy shall be the applicable premium for the remaining Insured Persons.

Refund of Unearned Premium - If a Insured Person dies, any premium paid to Us on behalf of the deceased for a period after the date of such death will be refunded on a pro-rata basis. Notice of death should be sent to Us within 12 months, or as soon as reasonably possible, after an Insured Person has died.

LifeShield National Insurance Company®
Administrative Office: 815 West Ash Ave., Duncan, OK 73533 Toll Free: 1-800-366-8354

ANNUAL CANCER SCREENING BENEFIT RIDER

This optional rider is effective only if the Annual Cancer Screening Benefit Rider is shown on the Policy Schedule as being included in this Policy. It is issued in consideration of the Application and the payment of the premium for this rider. If included, it is a part of the Policy and subject to all its provisions, conditions, exceptions, limitations and definitions unless modified herein.

EFFECTIVE DATE

The Effective Date of an Insured Person's coverage under this rider will be the later of:

1. the Effective Date of his or her coverage under the policy; or
2. the Policy Effective Date as shown on the Policy Schedule.

ANNUAL CANCER SCREENING BENEFIT

Basic Benefit - We will pay the Actual Charge, not to exceed the Maximum Benefit Amount per Calendar Year as shown on the Policy Schedule for the Annual Cancer Screening Benefit, per Insured Person for screening tests performed to determine whether Cancer exists in an Insured Person. Covered annual Cancer screening tests include but are not limited to the following:

Mammogram
Pap Smear
Flexible Sigmoidoscopy
Hemocult Stool Specimen
CEA (blood test for colon cancer)
PSA (blood test for prostate cancer)
CA 125 (blood test for ovarian cancer)
CA 15-3 (blood test for breast cancer)
Breast Ultrasound
ThinPrep
Biopsy
Chest X-Ray
Thermography
Colonoscopy
Serum Protein Electrophersis (blood test for myeloma)

Additional Benefit - We will pay the Actual Charge, not to exceed two times the Maximum Benefit Amount per Calendar Year as shown on the Policy Schedule for the Annual Cancer Screening Benefit, per Insured Person for one additional invasive diagnostic procedure required as the result of an abnormal cancer screening test for which benefits are payable under the Basic Benefit above. Invasive diagnostic procedure means a procedure requiring an excision or the insertion of an instrument in the body. This additional benefit is payable regardless of the results of the additional diagnostic procedure, however, the amount payable will be reduced dollar for dollar for any amount payable under the Positive Diagnosis Benefit contained within the base policy.

Secretary

President

LifeShield National Insurance Company®
Administrative Office: 815 West Ash Ave., Duncan, OK 73533 Toll Free: 1-800-366-8354

DAILY HOSPITAL CONFINEMENT BENEFIT RIDER

This optional rider is effective only if the Daily Hospital Confinement Benefit Rider is shown on the Policy Schedule as being included in this Policy. It is issued in consideration of the Application and the payment of the premium for this rider. If included, it is a part of the Policy and subject to all its provisions, conditions, exceptions, limitations and definitions unless modified herein.

EFFECTIVE DATE

The Effective Date of an Insured Person's coverage under this rider will be the later of:

1. the Effective Date of his or her coverage under the policy; or
2. the Policy Effective Date as shown on the Policy Schedule.

DAILY HOSPITAL CONFINEMENT EXPENSE BENEFITS

Confinements of 30 Days or Less - We will pay the Daily Hospital Confinement Benefit amount shown on the Policy Schedule for the Daily Hospital Confinement Benefit, for each of the first 30 days in each Period of Hospital Confinement during which an Insured Person is confined to a Hospital, including a Government or Charity Hospital, for the treatment of Cancer.

Confinements lasting longer than 30 Consecutive Days – If an Insured Person is continuously confined to a Hospital, including a Government or Charity Hospital, for longer than 30 consecutive days for the treatment of Cancer, We will pay two times the Daily Hospital Confinement Benefit amount shown on the Policy Schedule for the Daily Hospital Confinement Benefit. This benefit payment will begin on the 31st continuous day of such confinement and continue for each day of confinement until the Insured Person is discharged from the Hospital.

Benefits for an insured Dependent Child under Age 21 - Benefits payable under the Daily Hospital Confinement Expense Benefits will be double the Daily Hospital Confinement Benefit amount shown on the Policy Schedule for the Daily Hospital Confinement Benefit if the Insured Person so confined is a dependent child under the age of 21.

Secretary

President

LifeShield National Insurance Company®
Administrative Office: 815 West Ash Ave., Duncan, OK 73533 Toll Free: 1-800-366-8354

FIRST OCCURRENCE BENEFIT RIDER

This optional rider is effective only if the First Occurrence Benefit Rider is shown on the Policy Schedule as being included in this Policy. It is issued in consideration of the Application and the payment of the premium for this rider. If included, it is a part of the Policy and subject to all its provisions, conditions, exceptions, limitations and definitions unless modified herein.

EFFECTIVE DATE

The Effective Date of an Insured Person's coverage under this rider will be the later of:

1. the Effective Date of his or her coverage under the policy; or
2. the Policy Effective Date as shown on the Policy Schedule.

FIRST OCCURRENCE BENEFIT

If an Insured Person receives a positive diagnosis of Internal Cancer while insured under this Policy, We will pay the First Occurrence Benefit amount shown on the Policy Schedule.

If the Insured Person receiving the positive diagnosis of Internal Cancer is a child under the age of 21, We will pay one and one-half times the First Occurrence Benefit amount shown on the Policy Schedule.

This benefit is payable one time only during the lifetime of each Insured Person, regardless of the number of positive diagnoses that an Insured Person may have of Internal Cancer.

Secretary

President

LifeShield National Insurance Company®
Administrative Office: 815 West Ash Ave., Duncan, OK 73533 Toll Free: 1-800-366-8354

FIRST OCCURRENCE BUILDING BENEFIT RIDER

This optional rider is effective only if both the First Occurrence Benefit Rider and the First Occurrence Building Benefit Rider are shown on the Policy Schedule as being included in this Policy. It is issued in consideration of the Application and the payment of the premium for this rider. If included, it is a part of the Policy and subject to all its provisions, conditions, exceptions, limitations and definitions unless modified herein.

EFFECTIVE DATE

The Effective Date of an Insured Person's coverage under this rider will be the later of:

1. the Effective Date of his or her coverage under the policy; or
2. the Policy Effective Date as shown on the Policy Schedule.

FIRST OCCURRENCE BUILDING BENEFIT

While this rider is in effect, on the day following each Policy Anniversary of this policy, the First Occurrence Benefit amount shown on the Policy Schedule will be increased for each Insured Person by the First Occurrence Building Benefit amount shown on the Policy Schedule.

The First Occurrence Building Benefit, if any accrued, will be paid under the same terms and conditions as the First Occurrence Benefit Rider attached to this policy.

This First Occurrence Building Benefit will cease to annually increase for an Insured Person on the day following the first Policy Anniversary after the Insured Person's 65th birthday or on the date of positive diagnosis of Internal Cancer, whichever occurs first. However, regardless of the age of the Insured Person on the Effective Date of this rider, this benefit shall accrue for a period of at least five years unless Internal Cancer is diagnosed prior to the fifth year of coverage.

If the Coverage Type shown on the Policy Schedule is "Individual", no further premium will be billed for this rider after the payment of the First Occurrence benefit.

Secretary

President

LifeShield National Insurance Company®
Administrative Office: 815 West Ash Ave., Duncan, OK 73533 Toll Free: 1-800-366-8354

ANNUAL RADIATION, CHEMOTHERAPY, IMMUNOTHERAPY AND EXPERIMENTAL TREATMENT BENEFIT RIDER

This optional rider is effective only if the Annual Radiation, Chemotherapy, Immunotherapy and Experimental Treatment Benefit Rider is shown on the Policy Schedule as being included in this Policy. It is issued in consideration of the Application and the payment of the premium for this rider. If included, it is a part of the Policy and subject to all its provisions, conditions, exceptions, limitations and definitions unless modified herein.

EFFECTIVE DATE

The Effective Date of an Insured Person's coverage under this rider will be the later of:

1. the Effective Date of his or her coverage under the policy; or
2. the Policy Effective Date as shown on the Policy Schedule.

RADIATION TREATMENT, CHEMOTHERAPY, IMMUNOTHERAPY and EXPERIMENTAL TREATMENT EXPENSE BENEFIT

While this rider is in effect, We will pay the Actual Charge incurred in any one Calendar Year by an Insured Person for Radiation Treatment, Chemotherapy, Hormonal Therapy or Immunotherapy or Experimental Treatment not to exceed the Radiation Treatment, Chemotherapy, Immunotherapy or Experimental Treatment Benefit amount shown on the Policy Schedule for each Calendar Year. The Radiation Treatment, Chemotherapy, Hormonal Therapy, Immunotherapy or Experimental Treatment must be for the treatment of an Insured Person's Cancer. Treatments must be administered, or in the case of self-administered or oral chemotherapy or immunotherapy, prescribed by a Physician, Chemotherapist, Oncologist, Radiation Therapist or other licensed medical personnel as required by the applicable state law to administer the treatment. Treatment may be on an Inpatient or Outpatient basis.

The Radiation Treatment, Chemotherapy, Immunotherapy and Experimental Treatment Benefit amount shown on the Policy Schedule is the maximum We will pay in any one Calendar Year for each Insured Person's Cancer treatments regardless of the number or types of treatments received.

Secretary

President

LifeShield National Insurance Company®
Administrative Office: 815 West Ash Ave., Duncan, OK 73533 Toll Free: 1-800-366-8354

DAILY RADIATION, CHEMOTHERAPY, IMMUNOTHERAPY AND EXPERIMENTAL TREATMENT BENEFIT RIDER

This optional rider is effective only if the Daily Radiation, Chemotherapy, Immunotherapy and Experimental Treatment Benefit Rider is shown on the Policy Schedule as being included in this Policy. It is issued in consideration of the Application and the payment of the premium for this rider. If included, it is a part of the Policy and subject to all its provisions, conditions, exceptions, limitations and definitions unless modified herein.

EFFECTIVE DATE

The Effective Date of an Insured Person's coverage under this rider will be the later of:

1. the Effective Date of his or her coverage under the policy; or
2. the Policy Effective Date as shown on the Policy Schedule.

RADIATION TREATMENT, CHEMOTHERAPY, IMMUNOTHERAPY AND EXPERIMENTAL TREATMENT EXPENSE BENEFIT

While this rider is in effect, We will pay the Actual Charge incurred by an Insured Person, not to exceed the Radiation Treatment, Chemotherapy, Immunotherapy and Experimental Treatment Benefit amount shown on the Policy Schedule for each day an Insured Person receives one or more of the following Cancer treatments:

1. Chemotherapy (including Hormonal Therapy) or Immunotherapy injected by a Chemotherapist, an Oncologist, Physician or other legally qualified medical personnel in the office of an Oncologist or Physician, a Chemotherapy Treatment Center, a Hospital or Clinic;

2. Self-injected Chemotherapy or Immunotherapy drugs, limited to the maximum daily benefit amount per treatment.

3. Chemotherapy or Immunotherapy drugs dispensed by a pump or implant. This is limited to the maximum daily benefit amount for the initial prescription and an equal amount for each refill.

4. Oral Chemotherapy or Immunotherapy regardless of where administered. This is limited to the maximum daily benefit amount per prescription.

5. Radiation Treatment administered by a Radiation Therapist, an Oncologist, Physician or other legally qualified medical personnel in the office of an Oncologist or Physician, a Radiation Treatment Center, a Hospital or Clinic. Benefits payable for interstitial or intracavitary applications of Radiation Treatments are payable on the day of insertion only and not for each day the Radiation Treatment remains in the body.

6. Experimental Treatment

The Radiation Treatment, Chemotherapy, Immunotherapy Benefit or Experimental Treatment amount shown on the Policy Schedule is the maximum We will pay on any day an Insured Person receives a Chemotherapy, Immunotherapy, Radiation or Experimental Treatment, regardless of the type or number of different treatments the Insured Person may receive on the same day.

Secretary

President

LifeShield National Insurance Company®
Administrative Office: 815 West Ash Ave., Duncan, OK 73533 Toll Free: 1-800-366-8354

HOSPITAL INTENSIVE CARE UNIT BENEFIT RIDER

This optional rider is effective only if the Hospital Intensive Care Unit Benefit Rider is shown on the Policy Schedule as being included in this Policy. It is issued in consideration of the Application and the payment of the premium for this rider. If included, it is a part of the Policy and subject to all its provisions, conditions, exceptions, limitations and definitions unless modified herein.

EFFECTIVE DATE

The Effective Date of an Insured Person's coverage under this rider will be the later of:

1. the Effective Date of his or her coverage under the policy; or
2. the Policy Effective Date as shown on the Policy Schedule.

DEFINITONS

"Injury" - means sudden, unexpected and unintended injury which is independent of any Sickness. It must be caused by or the result of external and violent means that takes place while this rider is in force.

"Intensive Care Unit" - means a specifically designated part of a Hospital that provides the highest level of medical care for critically ill or injured persons and is restricted to patients whose medical condition necessitates such level of care. The Intensive Care Unit must be equipped with special life-saving equipment, services and monitoring devices. Patients in the Intensive Care Unit must be under constant and continuous care of Nurses assigned exclusively to the Intensive Care Unit. The Intensive Care Unit must be eligible to be listed as such by the American Hospital Association Guide. Intensive Care Unit also means a Cardiac Intensive Care Unit or Neonatal Intensive Care Unit that meets the standards set forth above. Hospital private or semi-private rooms, private monitored rooms, observation rooms, surgical recovery rooms, progressive care, intermediate care, telemetry units or other facilities are not considered Intensive Care Units.

"Period of Hospital Intensive Care Unit Confinement" - means the period of successive days the Insured Person is confined as an Inpatient in an Intensive Care Unit or a Step Down Unit. It begins on the date the Insured Person is confined as an Inpatient in an Intensive Care Unit or Step Down Unit. It ends on the Insured Person's date of discharge from that unit. Successive confinements due to the same or a related cause not separated by at least 30 days are considered to be a part of the same Period of Confinement.

"Sickness" - means an illness, disease or pregnancy for which treatment is given after the Effective Date and while this rider is in force.

"Step Down Unit" - means a specifically designated part of a Hospital that provides medical care to patients whose medical conditions do not require Intensive Care Unit confinement but do require services beyond that provided in regular hospital private or semi-private rooms, private monitored rooms, observation rooms or surgical recovery units. Hospital private or semi-private rooms, private monitored rooms, observation rooms or surgical recovery units are not considered Step Down Units.

"Travel Related Injury" - means an accidental bodily injury sustained directly and independently of all other causes from the Insured Person being struck by a vehicle including an automobile, bus, truck, van, motorcycle, airplane or train or being involved in an accident where the Insured Person was an operator or passenger in or on such vehicle.

HOSPITAL INTENSIVE CARE UNIT BENEFITS

Subject to all the terms, provisions, conditions, definitions, exclusions, limitations and reductions contained in this rider and the base policy, for covered Intensive Care Unit or Step Down Unit confinements which occur during a Period of Confinement that begins after the Insured Person's Effective Date of coverage We will pay the benefits described in A., B., or C., below.

A. Intensive Care Unit Benefit - We will pay the Daily Hospital Intensive Care Unit Benefit amount shown on the Policy Schedule for each day an Insured Person is confined in an Intensive Care Unit as the result of Sickness or Injury, subject to the following: (1) Intensive Care Unit Benefits will begin on the first day of such confinement. (2) However, We will not pay benefits for any more than 45 days during any one Period of Hospital Intensive Care Unit Confinement.

B. Double Intensive Care Unit Benefit - The Daily Hospital Intensive Care Unit Benefit payable for any one Period of Confinement that is the result of Cancer or as the result of a Travel Related Injury will be double the Hospital Intensive Care Unit Benefit shown on the Policy Schedule. The double benefit for a Travel Related Injury is payable only for the initial Intensive Care Unit confinement that commences within 24 hours of the accident causing the Travel Related Injury. Double benefits are not payable for successive periods of Intensive Care Unit confinement, even when part of the same Period of Confinement.

C. Step Down Unit Benefit - We will pay one-half of the Daily Hospital Intensive Care Unit Benefit shown on the Policy Schedule for each day the Insured Person is confined in a Step Down Unit as the result of Sickness or Injury.

During each Period of Confinement, W e will pay benefits for a maximum of 45 days under A., B., or C.

ADDITIONAL EXCLUSIONS and LIMITATIONS

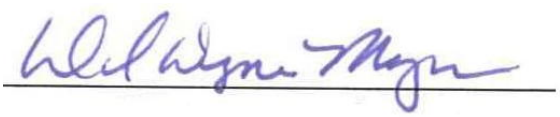
Coverage under this rider is subject to the applicable Exclusions and Limitations of the base policy to which it is attached. The following additional Exclusions, Reduction and Limitations also apply.

REDUCTION

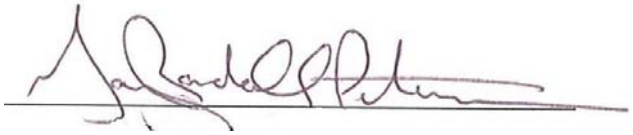
On the date an Insured Person attains Age 75, and continuing thereafter, his or her Daily Hospital Intensive Care Unit benefit will be reduced to an amount equal to one-half of the Daily Hospital Intensive Care Unit Benefit shown on the Policy Schedule.

EXCLUSIONS

This rider does not cover Intensive Care Unit or Step Down Unit confinements that are the result of (1) intentionally self-inflicted injury, or (2) the Insured Person being intoxicated or under the influence of alcohol, drugs or any narcotic, unless administered on and according to the advice of a Medical Practitioner. The term "intoxicated" means that condition as defined by law in the jurisdiction in which the cause of loss occurred.



Secretary



President

LifeShield National Insurance Company®
Administrative Office: 815 West Ash Ave., Duncan, OK 73533 Toll Free: 1-800-366-8354

SURGICAL BENEFITS RIDER

This optional rider is effective only if the Surgical Benefits Rider is shown on the Policy Schedule as being included in this Policy. It is issued in consideration of the Application and the payment of the premium for this rider. If included, it is a part of the Policy and subject to all its provisions, conditions, exceptions, limitations and definitions unless modified herein.

EFFECTIVE DATE

The Effective Date of an Insured Person's coverage under this rider will be the later of:

1. the Effective Date of his or her coverage under the policy; or
2. the Policy Effective Date as shown on the Policy Schedule.

SURGICAL EXPENSE BENEFIT

We will pay a Surgical Expense Benefit for a surgical procedure for the treatment of Cancer (except Skin Cancer) according to the following Surgical Schedule. The surgery may be performed either as an inpatient of a Hospital or as an outpatient in a Hospital, Ambulatory Surgical Center, Physician's office or other free standing medical facility.

The following rules apply to the Surgical Schedule shown below:

1. Two or more surgical procedures performed at the same time and through the same incision will be deemed one surgery, the surgery with the highest Surgical Benefit.
2. The procedures listed in the following Surgical Schedule are selected examples from a complete surgical schedule used by Us. For any surgical procedure not listed in the following Surgical Schedule, We will pay a benefit according to this complete schedule. However, in no event will the amount payable exceed the Maximum Benefit amount shown on the Policy Schedule. The complete Surgical Schedule is incorporated into this rider by reference and is available upon request.
3. One unit of coverage under this benefit provides a maximum benefit Amount of $1,000. The following amounts provide examples of benefits as they would be payable under this Surgical Schedule. The maximum Surgical Benefit amount for Your coverage under this rider will be shown on the Policy Schedule.
4. We will not pay more than the Actual Charge for any surgical procedure.

SURGICAL SCHEDULE

ABDOMEN	
Colonoscopy beyond splenic flexure	$ 140
Esophagogastroscopy	$ 83
Proctosigmoidoscopy (independent procedure)	$ 13
Colectomy partial, with colostomy	$ 550
Pancreatectomy Subtotal with or without Splenectomy	$ 433
BREAST	
Incisional Biopsy of Breast	$ 77
Mastectomy, Radical including Breast, Pectoral Muscles, and Axillary Lymph Nodes, Unilateral	$ 400
Mastectomy, Modified Radical with Modified Axillary dissection but leaving Pectoral M uscles, Unilateral	$ 350
Mammoplasty Augmentation Prosthetic (not including implants) Unilateral	$ 250
Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site, with microvascular anastomosis (supercharging)	$ 900

GENITO-URINARY TRACT

Nephrectomy including Partial Ureterectomy, any approach including Rib Resection		$ 383
Pelvic Exenteration complete for Vesical Prostatic or Uretheral Malignancy with removal of Bladder and Uteral Transplantation		$ 1,000
Cystourethroscopy with Biopsy	Hospital	$ 53
	Office	$ 33
Transurethral Resection of Prostate including control of postoperative bleeding during the initial hospitalization		$ 383
Orchiectomy radical for tumor inguinal Approach		$ 177
Dilation and Curettement of Cervical - Stump		$ 77
Total Hysterectomy (Corpus and Cervix) with or without tubes and/or ovaries, one or both		$ 333
Vaginal Hysterectomy		$ 330

LUNG

Pneumonectomy Total	$ 600
Lobectomy Total or Segmental	$ 500
Bronchoscopy	$ 80

NERVOUS SYSTEM

Excision Brain Tumor – Supratentorial Except Meningioma	$ 667
Laminectomy One or Two Segments for Intraspinal Lesion Cervical	$ 650

RECTUM

Proctectomy Complete Combined Absominoperineal	$ 517

ANESTHESIA EXPENSE BENEFIT

When a surgical procedure is performed that is a covered surgical expense and the Insured Person incurs charges for anesthesia, We will pay the Actual Charge for the anesthesia not to exceed an amount equal to 25% of the covered Surgical Expense Benefit for the operation performed. This includes the services of a professional anesthesiologist or of an anesthetist under supervision of a Physician for the purpose of administering anesthesia.

SKIN CANCER SURGERY EXPENSE BENEFIT

When there is a positive diagnosis of Skin Cancer of an Insured Person and a cutting surgical procedure is performed to remove the positively diagnosed Skin Cancer, We will pay the Actual Charge, not to exceed the amount shown below, for such surgical removal.

Biopsy	$ 125
Excision of lesion of skin	$ 350
Excision of lesion of skin with flap or graft	$ 750

This benefit is payable in lieu of any benefits for Surgical Expense and Anesthesia Expense which are not applicable to Skin Cancer.

Secretary

President

LifeShield National Insurance Company®
Administrative Office: 815 West Ash Ave., Duncan, OK 73533 Toll Free: 1-800-366-8354

SPECIFIED DISEASE BENEFIT RIDER

This optional rider is effective only if the Specified Disease Benefit Rider is shown on the Policy Schedule as being included in this Policy. It is issued in consideration of the Application and the payment of the premium for this rider. If included, it is a part of the Policy and subject to all its provisions, conditions, exceptions, limitations and definitions unless modified herein.

EFFECTIVE DATE

The Effective Date of an Insured Person's coverage under this rider will be the later of:

1. the Effective Date of his or her coverage under the policy; or
2. the Policy Effective Date as shown on the Policy Schedule.

COVERED SPECIFIED DISEASES

Addison's Disease
Amyotrophic Lateral Sclerosis
Botulism
Bovine Spongiform Encephalopathy
Budd-Chiari Syndrome
Cystic Fibrosis
Diphtheria
Encephalitis
Epilepsy
Hansen's Disease
Histoplasmosis
Legionnaire's Disease
Lupus Erythematosus
Lyme Disease
Malaria
Meningitis
Multiple Sclerosis
Muscular Dystrophy
Myasthenia Gravis
Neimann-Pick Disease
Osteomyelitis
Poliomyelitis
Q Fever
Rabies
Reye's Syndrome
Rheumatic Fever
Rocky Mountain Spotted Fever
Sickle Cell Anemia
Tay-Sachs Disease
Tetanus
Toxic Epidermal Necrolysis
Tuberculosis
Tularemia
Typhoid Fever
Undulant Fever
West Nile Virus
Whipple's Disease
Whooping Cough

BENEFITS

While coverage is in force, if an Insured Person is first diagnosed with one or more covered Specified Diseases and is hospitalized for the definitive treatment of any covered Specified Disease, We will pay benefits according to the provisions of this rider.

Initial Hospitalization Benefit: We will pay the Initial Hospitalization Benefit amount shown on the Policy Schedule when an Insured Person is confined to a Hospital for 12 or more hours as a result of receiving treatment for a Specified Disease. This benefit is payable only once per period of confinement and once per Calendar Year for each Insured Person.

A period of confinement is a Hospital confinement that starts while this rider is in force. If the confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless it is the result of an entirely different Specified Disease, or unless the confinements are separated by 30 days or more.

Hospital Confinement Benefit: We will pay the Hospital Confinement Benefit amount shown on the Policy Schedule per day when an Insured Person is hospitalized during any continuous period of 30 days or less for the treatment of a covered Specified Disease. Benefits will double per day beginning with the 31st day of continuous confinement.

EXCLUSIONS

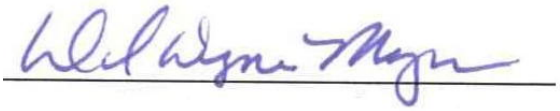
No benefits will be paid for:

1. loss due to any disease or illness other than those listed as covered Specified Diseases;
2. care and treatment received outside the territorial limits of the United States;
3. treatment that has not been approved by a Physician as being medically necessary; or
4. losses or medical expenses incurred prior to the Effective Date of an Insured Person's coverage regardless of the date of diagnosis.

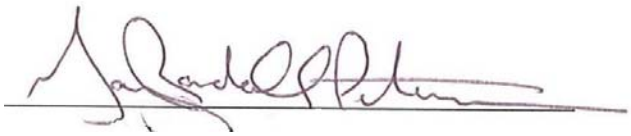
TERMINATION

This rider terminates on the earliest of the following:

1. the date the policy terminates;
2. when You fail to pay the required premium within its grace period; or
3. the premium due date on or next following the date we receive Your written request to terminate this rider.



Secretary



President

LifeShield National Insurance Company®
Administrative Office: 815 West Ash Ave., Duncan, OK 73533 Toll Free: 1-800-366-8354

LIMITED BENEFIT CANCER EXPENSE POLICY AMENDMENT

This Amendment is effective only if the Benefit Provision Amendment is shown on the Policy Schedule as being included in this Policy. If included it is a part of the Policy and subject to all policy provisions not in conflict with this amendment. If the Benefit Provision Amendment is included in this Policy, Part C of the Policy is amended to read as follows:

PART C BENEFIT PROVISIONS

We will pay the benefits described in PART D for the treatment of an Insured Person's Cancer, and if such optional rider is also issued, for the treatment of a listed Specified Disease provided he or she is covered under this Policy and/or rider and this Policy and/or rider remains in force. Payment will be made in accordance with all applicable Policy and/or rider provisions. Benefits are payable for a positive diagnosis that begins after the Effective Date. The positive diagnosis must be for Cancer as defined in this Policy, or for a Specified Disease as defined in the optional rider.

All benefits are subject to terms of this Policy and/or Specified Disease rider. If Cancer or a listed Specified Disease is diagnosed while You or any Insured Person is confined in the Hospital, benefits will begin on the day of admission or 10 days prior to the date of diagnosis if this is more favorable to You. Admission to the Hospital must begin after the Effective Date of coverage. If a positive diagnosis is made for Cancer or a listed Specified Disease within 12 months after a Tentative Diagnosis, benefits will be paid from the date of the Tentative Diagnosis if the Tentative Diagnosis is made after the Effective Date of coverage.

In all other respects, the Policy remains unchanged. This Amendment becomes effective as of the Effective Date of coverage.

Secretary

President

SERFF Tracking Number:	*RDWS-126450975*	*State:*	*Arkansas*
Filing Company:	*LifeShield National Insurance Co.*	*State Tracking Number:*	*45429*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*LifeShield LN-6040-AR Limited Benefit Cancer Expense*		
Project Name/Number:	*/*		

Rate Information

Rate data applies to filing.

Filing Method:	SERFF
Rate Change Type:	Neutral
Overall Percentage of Last Rate Revision:	%
Effective Date of Last Rate Revision:	
Filing Method of Last Filing:	

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
LifeShield National Insurance Co.	%	%				%	%

SERFF Tracking Number:	*RDWS-126450975*	*State:*	*Arkansas*
Filing Company:	*LifeShield National Insurance Co.*	*State Tracking Number:*	*45429*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*LifeShield LN-6040-AR Limited Benefit Cancer Expense*		
Project Name/Number:	*/*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved-Closed 04/28/2010	Rates	LN-6040-AR, LN-6041-AR, LN-6042-AR, LN-6043-AR, LN-6044-AR, LN-6045-AR, LN-6046-AR, LN-6047-AR, LN-6048-AR, LN-6052-AR	New		LN-6040 rates.pdf

LN-6040
Annual Premiums

Base Coverage – LN-6040

	Individual	S. Parent	Family
Group Payroll Deduction	$55.30	$59.00	$83.70
Direct Pay			
<40	$23.10	$34.10	$51.60
40-49	$50.90	$59.40	$101.00
50-65	$85.80	$88.30	$177.50
66-79	$128.30	$122.80	$209.30

Screening Benefit (per $25 unit of Part 1) – LN-6041

	Individual	S. Parent	Family
Group Payroll Deduction	$14.10	$16.40	$23.10
Direct Pay			
<40	$9.20	$11.60	$17.40
40-49	$14.30	$16.80	$26.60
50-65	$18.70	$20.90	$36.10
66-79	$23.50	$25.50	$45.60

First Occurrence Benefit (per $500 unit) – LN-6043

	Individual	S. Parent	Family
Group Payroll Deduction	$6.60	$7.20	$10.10
Direct Pay			
<40	$2.80	$4.50	$6.50
40-49	$6.00	$7.40	$12.20
50-65	$10.10	$10.60	$21.10
66-79	$15.20	$14.70	$34.30

Surgery & Anesthesia Benefit (per $500 unit) – LN- 6048

	Individual	S. Parent	Family
Group Payroll Deduction	$3.98	$4.41	$6.55
Direct Pay			
<40	$1.73	$2.50	$3.90
40-49	$3.82	$4.34	$7.67
50-65	$6.38	$6.36	$13.41
66-79	$9.47	$8.69	$21.28

Daily Indemnity/Extended Hospital Benefit (per $100 unit) – LN-6042

	Individual	S. Parent	Family
Group Payroll Deduction	$15.60	$19.10	$26.00
Direct Pay			
<40	$5.90	$10.70	$15.20
40-49	$14.90	$18.70	$30.60
50-65	$26.00	$27.70	$54.20
66-79	$38.00	$37.20	$83.90

Building Benefit Rider (per $100 unit) – LN-6044

	Individual	S. Parent	Family
Group Payroll Deduction	$7.70	$10.80	$15.60
Direct Pay			
<40	$5.40	$10.80	$14.00
40-49	$8.60	$14.60	$19.90
50-65	$7.40	$11.80	$16.60
66-79	$5.40	$8.40	$9.90

Annual Premiums (continued)

Radiation & Chemotherapy Benefit (base $500 day limit) – LN-6046

	Individual	S. Parent	Family
Group Payroll Deduction	$73.90	$86.20	$121.70
Direct Pay			
<40	$32.30	$48.80	$73.60
40-49	$75.30	$89.60	$148.70
50-65	$114.00	$119.60	$233.50
66-79	$142.40	$137.40	$283.30

Adjustment factors for other daily limits

Daily Max	Factor	Daily Max	Factor
$200	0.400	$600	1.200
$300	0.600	$700	1.400
$400	0.800	$800	1.600
$500	1.000	$900	1.800
		$1,000	2.000

Radiation & Chemotherapy Benefit (base $10,000 annual limit) – LN-6045

	Individual	S. Parent	Family
Group Payroll Deduction	$92.40	$107.60	$152.00
Direct Pay			
<40	$40.40	$60.90	$91.90
40-49	$94.00	$112.00	$185.90
50-65	$142.40	$149.40	$291.80
66-79	$177.90	$171.70	$354.00

Adjustment factors for other daily limits

Daily Max	Factor	Daily Max	Factor
$2,500	0.25	$12,500	1.25
$5,000	0.50	$15,000	1.50
$7,500	0.75	$17,500	1.75
$10,000	1.00	$20,000	2.00

ICU Rider (per $100 unit) – LN-6047

	Individual	S. Parent	Family
Group Payroll Deduction	$5.60	$7.70	$10.60
Direct Pay			
<40	$3.10	$5.80	$8.20
40-49	$5.40	$7.60	$11.70
50-65	$8.10	$9.60	$16.70
66-79	$10.30	$11.70	$18.30

Specified Disease Benefit Rider – LN-6052

	Individual	S. Parent	Family
Group Payroll Deduction	$5.90	$29.30	$30.00
Direct Pay			
<40	$6.80	$31.20	$32.50
40-49	$7.30	$27.00	$26.40
50-65	$7.60	$21.00	$18.20
66-79	$6.80	$19.70	$13.50

SERFF Tracking Number:	*RDWS-126450975*	*State:*	*Arkansas*
Filing Company:	*LifeShield National Insurance Co.*	*State Tracking Number:*	*45429*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*LifeShield LN-6040-AR Limited Benefit Cancer Expense*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	04/28/2010

Comments:

Attachment:

FLESCH.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	04/28/2010

Comments:

Attachments:

LN-6049-AR.pdf

LN-6050-AR.pdf

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	04/28/2010

Comments:

Attachment:

LN-6051-AR OLC.pdf

FLESCH READABILITY SCORE CERTIFICATION

LIFESHIELD NATIONAL INSURANCE COMPANY

I, Eddie Mire, am a consulting actuary doing work for LifeShield National Insurance Company. I certify that the following forms have been tested and meet the minimum required reading ease score. All forms have a 45+ score.

LN-6040-AR	Limited Benefit Cancer Expense Policy (offers limited benefit supplemental health insurance coverage)
LN-6041-AR	Optional Annual Cancer Screening Benefit Rider
LN-6042-AR	Optional Daily Hospital Confinement Benefit Rider
LN-6043-AR	Optional First Occurrence Benefit Rider
LN-6044-AR	Optional First Occurrence Building Benefit Rider
LN-6045-AR	Annual Radiation, Chemotherapy, Immunotherapy and Experimental Treatment Benefit Rider
LN-6046-AR	Daily Radiation, Chemotherapy. Immunotherapy and Experimental Treatment Benefit Rider
LN-6047-AR	Hospital Intensive Care Unit Benefit Rider
LN-6048-AR	Surgical Benefits Rider
LN-6052-AR	Specified Disease Benefit Rider
LN-6051-AR	Outline of Coverage
LN-6049-AR	Payroll application form
LN-6050-AR	Nonpayroll application form

April 14, 2010

Date

Eddie Mire
Rudd and Wisdom, Inc.

LifeShield National Insurance Company®
Administrative Office: 815 West Ash Ave., Duncan, OK 73533 Toll Free: 1-800-366-8354
Application Form for Cancer Insurance and Optional Riders
Application Form for Accident Expense Coverage

PAYROLL APPLICATION FORM
Requested Effective Date_____

Employer		Group Number		Billing Mode ☐ M ☐ SM ☐ BW ☐ W ☐ Other _____	
Applicant Proposed for Insurance (First, MI, Last)		S. S. Number		Employee Number	
☐ Emp ☐ Spouse ☐ Child ☐ Other	☐ Male ☐ Female	Age	Birth Date	Home Phone Number	
Home Address		City	State	Zip	
Job Title/Occupation	Do you normally work 20 or more hours per week for the Employer listed above? ☐ Yes ☐ No		State of Birth	Date Hired	
☐ Payor or ☐ Owner (if other than Proposed Insured) & Address		S.S. Number or Tax ID Number		Birth Date	
Primary Beneficiary - Full Name - Age - Relationship		Contingent Beneficiary - Full Name - Age - Relationship			

DEPENDENTS PROPOSED FOR INSURANCE

	Full Name	Sex		Birth Date
Spouse		☐ M	☐ F	
Children		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	

INSURANCE APPLIED FOR

Cancer Insurance (Includes Base Policy)	ASCB	FOB	FOBB*	RCIB required	SB	DHCB	SDB	ICUB	Modal Premium
☐ Individual ☐ One Parent ☐ Family	$_____ Per year	$_____ Lifetime maximum	$_____ Per year	$_____ ☐ Annual ☐ Daily	$_____ Per schedule	$_____ Per day	$_____ Per day	$_____ Per day	$
Accident Expense ☐ Individual ☐ One Parent ☐ Husband/Wife ☐ Family	☐ Plan A ☐ Plan B								$
Section 125 ☐ Yes ☐ No								**TOTAL MODAL PREMIUM**	**$**

MEDICAL QUESTIONNAIRE

1.	Are you actively at work now for the named employer and have you worked at least 20 hours each week performing all duties of your regular occupation at your regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?	☐ Yes ☐ No
2.	Within the past five years, has any person proposed for coverage been diagnosed as having, been treated for or, had care for which diagnostic test(s) have been recommended for: Cancer, (including hodgkin's disease, lymphoma, leukemia, melanoma or any other malignancy) other than Skin Cancer? If "yes", list name of person(s) _____ **who is/are to be excluded from coverage.**	☐ Yes ☐ No
3.	Within the past three years, has any person proposed for insurance been diagnosed as having, been treated for or, had care for which diagnostic test(s) have been recommended for Skin Cancer? If "yes", name of person(s) _____ **who is/are to be excluded from coverage for cancer of the skin.**	☐ Yes ☐ No

LN-6049-AR

***FOBB can only be purchased if FOB is also purchased.**

CONTINUED ON PAGE 2

MEDICAL QUESTIONNAIRE

4.	Has anyone proposed for coverage ever been diagnosed as having or treated by a member of the medical profession for: Acquired Immune Deficiency Syndrome (AIDS), "AIDS" Related Complex (ARC), or a condition or sickness derived from such infection, or tested positive for the Human Immuno-deficiency Virus (HIV) infection? If "Yes", list name of person(s)_____ **who is/are to be excluded from coverage**.	☐ Yes ☐ No
If Optional Specified Disease Rider is Applied for, Answer this Question.		
5.	Within the past five years, has any person proposed for coverage been diagnosed as having, been treated for, or had care for which diagnostic test(s) have been recommended for: Addison's Disease; Amyotrophic Lateral Sclerosis; Botulism; Bovine Spongiform Encephalopathy; Budd-Chiari Syndrome; Cystic Fibrosis; Diptheria; Encephalitis; Epilepsy; Hansen's Disease; Histoplasmosis; Legionaire's Disease; Lupus Erythematosus; Lyme Disease; Malaria; Meningitis; Multiple Sclerosis; Muscular Dystrophy; Myasthenia Gravis; Nieman-Pick Disease; Osteomyelitis; Poliomyelitis; Q Fever; Rabies; Reye's Syndrome; Rheumatic Fever; Rocky Mountain Spotted Fever; Sickle Cell Anemia; Tay-Sachs Disease; Tetanus; Toxic Epidermal Necrolysis; Tuberculosis; Tularemia; Typhoid Fever; Undulant Fever; West Nile Virus; Whipple's Disease or Whooping Cough? If "yes", list name of person(s) and Specified Disease:_____ **who is/are to be excluded from coverage for the listed Specified Disease.**	☐ Yes ☐ No
If Optional Intensive Care Unit Rider is Applied for, Answer this Question.		
6.	Has any person to be insured ever been diagnosed or treated for a heart attack, heart condition, heart trouble, angina or any abnormality of the heart prior to this date? If "yes", name of person_____ **who is to be excluded from coverage for any intensive care confinement resulting from any disorder of the heart and shall be limited to three days in connection with any other intensive care confinement.** **The person(s) named above will be excluded from coverage as follows:** We will not be liable for any loss for Hospital Intensive Care Unit confinement resulting from any disease or disorder of the heart. Furthermore, the benefits for such person(s) for confinement in a Hospital Intensive Care Unit will be limited to three days in connection with any one hospitalization for all other sickness, not the 45 days as stated in the Rider. Nothing herein shall affect benefits for any covered Hospital Intensive Care Unit confinement resulting from an Injury.	☐ Yes ☐ No

NON-MEDICAL QUESTIONNAIRE

1.	Is any proposed insured eligible for Medicare? If "yes" review the Guide to Health Insurance for People with Medicare which is available from the company.	☐ Yes ☐ No
2.	Is any proposed insured eligible for Medicaid? **(If "Yes" applying for coverage on that person is not appropriate.)**	☐ Yes ☐ No
3.	**Existing Insurance**. Is any proposed insured covered under major medical insurance or an HMO? If "Yes", list name of proposed insured, coverage type, and insurance company.	☐ Yes ☐ No
4.	**Replacement.** Is the insurance applied for to replace or change any existing insurance? If "Yes" list coverage and name of company._____ and complete any required replacement form(s) provided by your agent and return with this application.	☐ Yes ☐ No
5.	Have you received any required Outline of Coverage?	☐ Yes ☐ No

AGREEMENT: I have read or had read to me the completed application form and any supplement, and my statements and answers are true and complete, to the best of my knowledge and belief. I understand that any material misstatement or misrepresentation may result in loss of coverage. I understand that the effective date of the coverage will be the date stated on the Policy's schedule page, not the date this application form is signed. I understand that no agent can accept risks, modify policies, or waive any rights or requirements of LifeShield National.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Applicant: X _____ **Date:** _____

Affidavit for Agent's Use Only: I hereby certify that I have truly recorded in this application the information supplied by the applicant. I also certify that the applicant has read or had read to him or her the completed application.

Licensed Resident Agent's Signature _____ Licensed Resident Agent's No. _____

Agent's Name: (please print) _____ State License No _____

Authorization and Request for Payroll Deductions

I have applied for Cancer insurance with LifeShield National Insurance Company and I hereby authorize and request that you, my employer, deduct from my salary or wages the necessary amounts to pay the premiums for this insurance and forward it to LifeShield National. If premiums for the insurance to which this authorization applies are part of a Cafeteria Plan, I understand that this authorization may not be revoked until the end of the Plan Year and only then by my written request. Otherwise, this authorization shall remain in effect until revoked in writing by me.

Per Pay Period Initial Premium Amount:$_____ Employer:_____

_____ _____ _____

Employee Signature | Social Security or Employee Number | Date

PRD AUTHORIZATION

LifeShield National Insurance Company®
Administrative Office: 815 West Ash Ave., Duncan, OK 73533 Toll Free: 1-800-366-8354
Application Form for Cancer Insurance and Optional Riders

NONPAYROLL APPLICATION FORM

Employer		Group Number	Billing Mode ☐ M PAC ☐ Q ☐ SA ☐ A ☐ Other_____	
Applicant Proposed for Insurance (First, MI, Last)		S. S. Number	Employee Number	
☐ Emp ☐ Spouse ☐ Child ☐ Other	☐ Male ☐ Female	Age	Birth Date	Home Phone Number
Home Address		City	State	Zip
Job Title/Occupation	Do you normally work 20 or more hours per week for the Employer listed above? ☐ Yes ☐ No		State of Birth	Date Hired
☐ Payor or ☐ Owner (if other than Proposed Insured) & Address		S.S. Number or Tax ID Number	Birth Date	

DEPENDENTS PROPOSED FOR INSURANCE

	Full Name	Sex		Birth Date
Spouse		☐ M	☐ F	
Children		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	

INSURANCE APPLIED FOR

Cancer Insurance (Includes Base Policy)	ASCB	FOB	FOBB*	RCIB required	SB	DHCB	SDB	ICUB	Modal Premium
☐ Individual ☐ One Parent ☐ Family	$_____ Per year	$_____ Lifetime maximum	$_____ Per year	$ ☐ Annual ☐ Daily	$_____ Per schedule	$_____ Per day	$_____ Per day	$_____ Per day	$

MEDICAL QUESTIONNAIRE

1.	Within the past ten years, has any person proposed for coverage been diagnosed as having, been treated for, or had care for which diagnostic test(s) have been recommended for: Cancer, (including hodgkin's disease, lymphoma, leukemia, melanoma or any other malignancy) other than Skin Cancer? If "yes", list name of person(s) _____ **who is/are to be excluded from coverage.**	☐ Yes ☐ No
2.	Within the past five years, has any person proposed for insurance been diagnosed as having, been treated for, or had care for which diagnostic test(s) have been recommended for Skin Cancer? If "yes", name of person(s) _____ **who is/are to be excluded from coverage for cancer of the skin.**	☐ Yes ☐ No

***FOBB can only be purchased if FOB is also purchased.**

LN-6050-AR

CONTINUED ON PAGE 2

	MEDICAL QUESTIONNAIRE	
3.	Has anyone proposed for coverage ever been diagnosed as having or treated by a member of the medical profession for: Acquired Immune Deficiency Syndrome (AIDS), "AIDS" Related Complex (ARC), or a condition or sickness derived from such infection, or tested positive for the Human Immuno-deficiency Virus (HIV) infection? If "Yes", list name of person(s) _____ **who is/are to be excluded from coverage.**	☐ Yes ☐ No
If Optional Specified Disease Rider is Applied for, Answer this Question.		
4.	Within the past ten years, has any person proposed for coverage been diagnosed as having, been treated for, or had care for which diagnostic test(s) have been recommended for: Addison's Disease; Amyotrophic Lateral Sclerosis; Botulism; Bovine Spongiform Encephalopathy; Budd-Chiari Syndrome; Cystic Fibrosis; Diptheria; Encephalitis; Epilepsy; Hansen's Disease; Histoplasmosis; Legionaire's Disease; Lupus Erythematosus; Lyme Disease; Malaria; Meningitis; Multiple Sclerosis; Muscular Dystrophy; Myasthenia Gravis; Nieman-Pick Disease; Osteomyelitis; Poliomyelitis; Q Fever; Rabies; Reye's Syndrome; Rheumatic Fever; Rocky Mountain Spotted Fever; Sickle Cell Anemia; Tay-Sachs Disease; Tetanus; Toxic Epidermal Necrolysis; Tuberculosis; Tularemia; Typhoid Fever; Undulant Fever; West Nile Virus; Whipple's Disease or Whooping Cough? If "yes", list name of person(s) and Specified Disease:_____ **who is/are to be excluded from coverage for the listed Specified Disease.**	☐ Yes ☐ No
If Optional Intensive Care Rider is Applied for, Answer this Question.		
5.	Has any person to be insured ever been diagnosed or treated for a heart attack, heart condition, heart trouble, angina or any abnormality of the heart prior to this date? If "yes", name of person _____ **who is to be excluded from coverage.**	☐ Yes ☐ No
	NON-MEDICAL QUESTIONNAIRE	
1.	Is any proposed insured eligible for Medicare? If "yes" review the Guide to Health Insurance for People with Medicare which is available from the company.	☐ Yes ☐ No
2.	Is any proposed insured eligible for Medicaid? **(If "Yes" applying for coverage on that person is not appropriate.)**	☐ Yes ☐ No
3.	**Existing Insurance**. Is any proposed insured covered under major medical insurance or an HMO? If "Yes", list name of proposed insured, coverage type, and insurance company.	☐ Yes ☐ No
4.	**Replacement.** Is the insurance applied for to replace or change any existing insurance? If "Yes" list coverage and name of company._____ and complete any required replacement form(s) provided by your agent and return with this application.	☐ Yes ☐ No
5.	Have you received any required Outline of Coverage?	☐ Yes ☐ No

AGREEMENT: I have read or had read to me the completed application form and any supplement, and my statements and answers are true and complete, to the best of my knowledge and belief. I understand that any material misstatement or misrepresentation may result in loss of coverage. I understand that the effective date of the coverage will be the date stated on the Policy's schedule page, not the date this application form is signed. I understand that no agent can accept risks, modify policies, or waive any rights or requirements of LifeShield National.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Applicant: X _____ **Date:** _____

Affidavit for Agent's Use Only: I hereby certify that I have truly recorded in this application the information supplied by the applicant. I also certify that the applicant has read or had read to him or her the completed application.

Licensed Resident Agent's Signature _____ Licensed Resident Agent's No. _____

Agent's Name: (please print) _____ State License No. _____

RECEIPT

ALL PREMIUM CHECKS MUST BE PAYABLE TO "LifeShield National Insurance Company"

DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK

Received from _____ an application for Cancer Insurance and the sum of $_____ for _____ month's premium. The effective date of the coverage will be the date stated on the Policy's schedule page, not the date of this receipt. If the policy applied for is not issued within 60 days, the amount paid will be refunded.

Agent's Signature _____ Agent's Telephone Number _____ Date _____

Agent's Address: _____ City: _____ St_____ Zip_____

If you have not received a policy or a refund of premium within 60 days of the date of this receipt, contact LifeShield National Insurance Company

Administrative Office: 815 West Ash Ave., Duncan, OK 73533 Toll Free: 1-800-366-8354

LifeShield National Insurance Company®

Administrative Office: 815 West Ash Ave., Duncan, OK 73533 Toll Free: 1-800-366-8354

OUTLINE OF COVERAGE for CANCER EXPENSE POLICY FORM LN-6040-AR

THE POLICY DESCRIBED IN THIS OUTLINE OF COVERAGE PROVIDES SUPPLEMENTAL COVERAGE AND IS DESIGNED TO SUPPLEMENT EXISTING INSURANCE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

If you are eligible for Medicare, please review the "Guide to Health Insurance for People with Medicare" which is available from the Company.

I. Read Your Policy Carefully. This outline of coverage provides a very brief description of some of the important features of the policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and the Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

II. Cancer Insurance Coverage - The policy is designed to provide a benefit when an Insured Person is diagnosed with Cancer, is hospitalized or incurs certain medical expenses as a direct result of Cancer. It does not provide coverage for basic hospital, basic medical-surgical, or major medical coverage.

III. Benefits - We will pay the benefits as described in the policy for the treatment of an Insured Person's Cancer, and if such optional rider is also issued, for the treatment of a listed Specified Disease provided he or she is covered under this Policy and/or rider and this Policy and/or rider remains in force. Payment will be made in accordance with all applicable Policy and/or rider provisions. Benefits are payable for a positive diagnosis that begins more than 30 days after the Effective Date. The positive diagnosis must be for Cancer as defined in this Policy, or for a Specified Disease as defined in the optional rider.

All benefits are subject to terms and conditions of this Policy and/or Specified Disease rider. If Cancer or a listed Specified Disease is diagnosed while You or any Insured Person is confined in the Hospital, benefits will begin on the day of admission or 10 days prior to the date of diagnosis if this is more favorable to You. Admission to the Hospital must begin more than 30 days after the Effective Date of coverage. If a positive diagnosis is made for Cancer or a listed Specified Disease within 12 months after a Tentative Diagnosis, benefits will be paid from the date of the Tentative Diagnosis if the Tentative Diagnosis is made more than 30 days after the Effective Date of coverage.

Description of Benefits:

Positive Diagnosis Benefit - We will pay the Actual Charge not to exceed $300 per Calendar Year for one test that confirms the positive diagnosis of Cancer in an Insured Person. This benefit is not payable for multiple diagnoses of the same Cancer or for Cancer that metastasizes or for recurrence of the same Cancer.

National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation / Consultation Benefit - If an Insured Person receives a positive diagnosis of Internal Cancer and seeks an evaluation or consultation at a National Cancer Institute designated Comprehensive Cancer Treatment Center for the purpose of obtaining a treatment option opinion, We will pay the Actual Charge not to exceed a lifetime maximum of $750. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the Insured Person's place of residence, We will also pay the transportation and lodging expenses incurred not to exceed a lifetime maximum of $350. This benefit is not payable on the same day a Second or Third Surgical Opinion Benefit is payable. This benefit is payable in lieu of the Non-Local Transportation and Lodging Expense Benefits of the policy. This benefit is payable one time during the lifetime of the Insured Person.

Second and Third Surgical Opinion Expense Benefit – If surgery is recommended for the removal of Cancer, We will pay the Actual Charge for a written second surgical opinion concerning the Cancer surgery. If the second surgical opinion is in conflict with that of the Physician originally recommending the surgery, We will pay the Actual Charge for a written third surgical opinion. The Physician providing the second or third surgical opinion cannot be associated with the Physician who originally recommended the surgery. This benefit is not payable for the same day the National Cancer Institute Evaluation/Consulting Benefit is payable.

Outpatient Hospital or Ambulatory Surgical Center Expense Benefit - We will pay the Actual Charge, not to exceed $350 per day, made by an Ambulatory Surgical Center or Outpatient department of a Hospital for the use of its facilities during the performance of a surgical procedure covered under the policy.

Medical Imaging, Treatment Planning and Monitoring Expense Benefit - We will pay the Actual Charge not to exceed $1,000 per Calendar Year, for laboratory tests, routine or diagnostic X-rays, scans or medical images and their interpretation when used in the planning or monitoring of external radiation, internal radiation, Chemotherapy or Immunotherapy treatments of Cancer.

Anti-Nausea Medication Expense Benefit - We will pay the Actual Charge for anti-nausea medication not to exceed $150 per Calendar Month when an Insured Person is prescribed such medication as the result of Radiation Treatment, Chemotherapy or Immunotherapy treatments for Cancer.

Colony Stimulating Factor or Immunoglobulin Expense Benefit - We will pay the Actual Charge not to exceed $1,000 per calendar month for Colony Stimulating Factor Drugs or Immunoglobulins prescribed by a Physician or Oncologist during an Insured Person's Cancer treatment regimen for which benefits are payable under the Radiation, Chemotherapy and Immunotherapy Benefit of the policy or any rider attached to it.

Outpatient Blood, Plasma and Platelets Expense Benefit - If, as the result of Cancer, an Insured Person requires blood, plasma, platelets or blood transfusions, on an Outpatient basis, We will pay the Actual Charge not to exceed $300 per day including the costs of procurement, administration, processing and cross matching.

Inpatient Blood, Plasma and Platelets Expense Benefit - If, as the result of Cancer, an Insured Person requires blood, plasma, platelets or blood transfusions, on an Inpatient basis, We will pay the Actual Charge not to exceed $300 per day including the costs of procurement, administration, processing and cross matching.

Bone Marrow Donor Expense Benefit - When an Insured Person receives bone marrow or stem cells from another live person for the purpose of a bone marrow or stem cell transplant in connection with the Insured Person's Internal Cancer treatment, We will pay the Daily Hospital Confinement Benefit amount shown on the Policy Schedule for each day the donor is confined in a Hospital for the harvesting of bone marrow or stem cells used in a covered bone marrow or stem cell transplant.

Bone Marrow or Stem Cell Transplant Expense Benefit - We will pay the Actual Charge not to exceed a lifetime maximum of $15,000 for surgical and anesthesia procedures (including the harvesting and subsequent re-infusion of blood cells or peripheral stem cells) performed for a bone marrow transplant and/or a peripheral stem cell transplant for the treatment of an Insured Person's Internal Cancer**.** This benefit will be paid in lieu of the Surgical Expense Benefit and the Anesthesia Expense Benefit which may be described in a rider attached to the policy.

Inpatient Oxygen Expense Benefit – When an Insured Person is confined to a Hospital for the treatment of Cancer and requires oxygen that is prescribed and ordered by a Physician, We will pay the Actual Charge for the oxygen not to exceed $300 per Hospital confinement.

Attending Physician Expense Benefit - We will pay the Actual Charge not to exceed $ 40 per day for the professional services of a Physician or Oncologist rendered to an Insured Person while he or she is confined in a Hospital for the treatment of Cancer. This benefit is payable only if the Physician or

Oncologist personally visits the Hospital room occupied by the Insured Person. The benefit amount stated is the maximum amount payable for each day of Hospital confinement regardless of the number of visits made by one or more Physicians or Oncologists.

Inpatient Private Duty Nursing Expense Benefit - We will pay the Actual Charge not to exceed $150 per day for the full time service of a Nurse that is required and ordered by a Physician when an Insured Person is confined in a Hospital for the treatment of Cancer. The Nurse must provide services other than those normally provided by the Hospital. The Nurse may not be an employee of the Hospital or an Immediate Family Member of the Insured Person.

Outpatient Private Duty Nursing Expense Benefit – Following a period of Hospital confinement of an Insured Person for the treatment of Cancer, We will pay the Actual Charge not to exceed $ 150 per day, limited to the same number of days of the prior Hospital confinement, for the full time service of a Nurse that is required and ordered by a Physician when an Insured Person is confined indoors at home as the result of Cancer. This benefit is not payable if the services of the Nurse are custodial in nature or to assist the Insured Person in the activities of daily living. This benefit is not payable when the Nurse is a member of the Insured Person's Immediate Family.

Home Health Care Expense Benefit - We will pay benefits for the following covered charges when an Insured Person requires Home Health Care for the treatment of Cancer.

1. Home Health Care Visits - We will pay the Actual Charge for Home Health Care Visits not to exceed $ 75 for each day on which one or more such visits occur. We will not pay this benefit for more than 60 days in any Calendar Year.
2. Medicine and Supplies - We will pay the Actual Charge not to exceed $ 450 in any Calendar Year for drugs, medicine, and medical supplies provided by or on behalf of a Home Health Care Agency.
3. Services of a Nutritionist - We will pay the Actual Charge not to exceed a lifetime maximum of $ 300 for the services of a nutritionist to set up programs for special dietary needs.

Convalescent Care Facility Expense Benefit - We will pay the Actual Charge not to exceed $ 100 per day for an Insured Person's confinement in a Convalescent Care Facility. The maximum number of days for which this benefit is payable will be the number of days in the last Period of Hospital Confinement that immediately preceded admission to the Convalescent Care Facility. The Convalescent Care Facility confinement must:

1. be due to Cancer;
2. begin within 14 days after the Insured Person has been discharged from a Hospital for the treatment of Cancer; and
3. be authorized by a Physician as being medically necessary for the treatment of Cancer.

Hospice Care Expense Benefit – When an Insured Person, as a result of Cancer, requires Hospice Care, We will pay the Actual Charge for Hospice Care not to exceed $ 100 per day. This benefit is payable whether confinement is required in a Hospice Center or services are provided in the Insured Person's home by a Hospice Team. Eligibility for benefit payments will be based on the following conditions being met: (1) the Insured Person has been given a prognosis of being Terminally Ill with an estimated life expectancy of 6 months or less; and (2) We have received a written summary of such prognosis from the attending Physician. We will not pay this benefit while the Insured Person is confined to a Hospital or Convalescent Care Facility. The lifetime maximum benefit is 365 days of Hospice Care.

Non-Local Transportation Expense Benefit - We will pay the Actual Charge for Non-Local transportation not to exceed coach fare by on a Common Carrier for the Insured Person and one adult companion's travel to a Hospital, Radiation Therapy Treatment Center, Chemotherapy Treatment Center, Oncology Clinic or any other specialized treatment center where the Insured Person receives treatment for Cancer. This benefit is payable only if the treatment is not available Locally but is available Non-Locally. The adult companion may include the live donor of bone marrow or stem cells used in a bone marrow or stem cell transplant for the Insured Person. At the option of the Insured Person, We will pay a single private vehicle mileage allowance of 50 cents per mile for Non-Local transportation in lieu of the common carrier coach fare.

Lodging Expense Benefit - When an Insured Person receives treatment for Cancer at a Non-Local

Hospital, Radiation Therapy Treatment Center, Chemotherapy Treatment Center, Oncology Clinic or any other specialized treatment center, We will pay the Actual Charge not to exceed $ 75 per day for a room in a motel, hotel or other appropriate lodging facility (other than a private residence). The room must be occupied by the Insured Person or an adult companion, which may include the live donor of bone marrow or stem cells used in a bone marrow or stem cell transplant for the Insured Person. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment, nor for lodging expense incurred more than 24 hours following treatment. This benefit is limited to 100 days per Calendar Year.

Ambulance Expense Benefit - We will pay the Actual Charge for ambulance service if an Insured Persons is transported to a Hospital where he or she is admitted as an Inpatient for the treatment of Cancer. The ambulance service must be provided by a licensed professional ambulance company or an ambulance owned by the Hospital.

Prosthesis Expense Benefit:

(a) Surgically Implanted Breast Prosthesis – If, as the result of breast removal due to Cancer, the attending Physician prescribes a breast prosthesis to restore normal body contour, We will pay the Actual Charge for the prosthesis and its implantation. This benefit does not include coverage for breast reconstruction surgery which may be covered under the Surgical Schedule within the Surgical and Anesthesia Benefits Rider, if such rider is issued as part of the policy.

(b) Non-Surgically Implanted Prosthesis – If an Insured Person sustains an amputation, as the result of treatment for Cancer, and an artificial limb or other non-surgically implanted prosthetic device is required and prescribed by a Physician to restore normal body function, We will pay the Actual Charge not to exceed a lifetime maximum of $ 2,000 per such amputation. The cost for the replacement of a prosthetic device is not covered. Hairpieces or wigs are not covered under this benefit.

Hairpiece Expense Benefit – If an Insured Person suffers hair loss due to Cancer treatments, We will pay the Actual Charge not to exceed a lifetime maximum of $150 for the purchase of a wig or hairpiece.

Rental or Purchase of Medical Equipment Expense Benefit – If, as the result of Cancer, the attending Physician prescribes covered medical equipment designed for home use, We will pay the lesser of the Actual Charge for the rental or purchase of such medical equipment not to exceed $1,500 per Calendar Year. Covered medical equipment includes wheel chair, oxygen equipment, respirator, braces, crutches or hospital bed.

Physical, Speech, Audio Therapy and Psychotherapy Expense Benefit - We will pay the Actual Charge not to exceed $ 25 per therapy session for:

1. Physical therapy treatments given by a licensed Physical Therapist, or
2. Speech therapy given by a licensed Speech Pathologist/Therapist; or
3. Audio therapy given by a licensed Audiologist; or
4. Psychotherapy given by a licensed Psychologist.

These therapy sessions may be given at an institute of physical medicine and rehabilitation, a Hospital, or the Insured Person's home. These treatments must be given on an Outpatient basis, unless the primary purpose of a Hospital confinement is for treatment of Cancer other than with physical, speech or audio therapy or psychotherapy. Benefits under this section may not exceed $1,000 per Calendar Year.

Waiver of Premium Benefit - We will waive the premiums starting on the first premium due date following a 60 day period of Total Disability of the Named Insured due to Cancer. The Named Insured must: (1) be receiving treatment for such Cancer for which benefits are payable under this Policy; and (2) remain disabled for 60 consecutive days. We will waive premiums for as long as the Named Insured remains Totally Disabled. Premiums will be waived in accordance with the mode of payment in effect when treatment began.

Totally Disabled means the Named Insured is: (1) unable to work at any job for which he or she is qualified by education, training or experience; and (2) under the care of a Physician for the treatment of internal Cancer.

If the Named Insured is retired or Age 65 and over at the time he or she becomes Totally Disabled, the definition of Total Disability will mean the inability to perform two (2) or more of the ADL's (Activities of Daily Living) listed below without the assistance of another person. ADL's are defined as activities used in measuring levels of personal functioning capacity. Normally, these activities are performed without assistance, allowing personal independence in everyday living. The ADL's are:

1. Transferring - moving between the bed and a chair or the bed and a wheelchair;
2. Dressing - putting on and taking off all necessary items of clothing;
3. Toileting - getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene;
4. Eating - all major tasks of getting food into the body;
5. Bathing - getting into or out of the tub or shower and otherwise washing the parts of the body.

We may ask for and use an independent consultant to determine whether the Named Insured can perform an ADL when this benefit is in force.

IV. Exclusions and Limitations - No benefits will be paid for:

1. any loss due to any disease or illness other than Cancer;
2. care and treatment received outside the territorial limits of the United States;
3. treatment by any program engaged in research that does not meet the criteria for Experimental Treatment as defined;
4. treatment that has not been approved by a Physician as being medically necessary; or
5. losses or medical expenses incurred prior to the Effective Date of an Insured Person's coverage regardless of the Date of Positive Diagnosis.

Pre-Existing Condition(s) Limitation - "Pre-existing Condition" means Cancer, or a listed Specified Disease if that optional rider is issued, which was diagnosed by a Physician or for which medical consultation, advice or treatment was recommended by or received from or sought from a Physician within five years prior to the effective date of coverage for each Insured Person.

The benefits of this policy will not be payable during the first 24 months that coverage is in force with respect to an Insured Person for a loss caused by a Pre-Existing Condition disclosed or not disclosed on the application. This 24-month period is measured from the effective date of coverage for each Insured Person.

V. Guaranteed Renewable - Except for fraud or material misrepresentation, you will have the right to renew the Policy for your lifetime, as long as premiums are paid on time. The Policy will terminate on the last day of the period for which premium is paid unless continued in force during a Grace Period. We reserve the right to change premiums. On any premium due date after the first Policy Anniversary, We may change the premium rates for the policy only if We also change the rates for all other policies issued in the same rating class. We must give 60 days advance written notice of any premium change. No change in the premiums will be made because of the number of claims you file nor because of a change in your health.

VI. Optional Benefit Riders - A checkmark in any of the boxes below indicates that You have selected the following optional coverage(s):

☐ **ANNUAL CANCER SCREENING BENEFIT RIDER LN-6041-AR**

Basic Benefit - We will pay the Actual Charge, not to exceed the Maximum Benefit Amount per Calendar Year as shown on the Policy Schedule for the Annual Cancer Screening Benefit, per Insured Person for screening tests performed to determine whether Cancer exists in an Insured Person. Covered annual Cancer screening tests include but are not limited to the following:

Mammogram	Breast Ultrasound
Pap Smear	ThinPrep
Flexible Sigmoidoscopy	Biopsy
Hemocult Stool Specimen	Chest X-Ray
CEA (blood test for colon cancer)	Thermography
PSA (blood test for prostate cancer)	Colonoscopy

CA 125 (blood test for ovarian cancer) Serum Protein Electrophersis (blood test for myeloma)
CA 15-3 (blood test for breast cancer)

Additional Benefit - We will pay the Actual Charge, not to exceed two times the Maximum Benefit Amount per Calendar Year as shown on the Policy Schedule for the Annual Cancer Screening Benefit, per Insured Person for one additional invasive diagnostic procedure required as the result of an abnormal cancer screening test for which benefits are payable under the Basic Benefit above. Invasive diagnostic procedure means a procedure requiring an excision or the insertion of an instrument in the body. This additional benefit is payable regardless of the results of the additional diagnostic procedure, however, the amount payable will be reduced dollar for dollar for any amount payable under the Positive Diagnosis Benefit contained within the base policy.

☐ **DAILY HOSPITAL CONFINEMENT BENEFIT RIDER LN-6042-AR**

Confinements of 30 Days or Less - We will pay the Daily Hospital Confinement Benefit amount shown on the Policy Schedule for the Daily Hospital Confinement Benefit, for each of the first 30 days in each Period of Hospital Confinement during which an Insured Person is confined to a Hospital, including a Government or Charity Hospital, for the treatment of Cancer.

Confinements lasting longer than 30 Consecutive Days – If an Insured Person is continuously confined to a Hospital, including a Government or Charity Hospital, for longer than 30 consecutive days for the treatment of Cancer, We will pay two times the Daily Hospital Confinement Benefit amount shown on the Policy Schedule for the Daily Hospital Confinement Benefit. This benefit payment will begin on the 31st continuous day of such confinement and continue for each day of confinement until the Insured Person is discharged from the Hospital.

Benefits for an insured Dependent Child under Age 21 - Benefits payable under the Daily Hospital Confinement Expense Benefits will be double the Daily Hospital Confinement Benefit amount shown on the Policy Schedule for the Daily Hospital Confinement Benefit if the Insured Person so confined is a dependent child under the age of 21.

☐ **FIRST OCCURRENCE BENEFIT RIDER LN-6043-AR**

If an Insured Person receives a positive diagnosis of Internal Cancer while insured, We will pay the First Occurrence Benefit amount shown on the Policy Schedule. If the Insured Person receiving the positive diagnosis of Internal Cancer is a child under the age of 21, We will pay one and one-half times the First Occurrence Benefit amount shown on the Policy Schedule. This benefit is payable one time only during the lifetime of each Insured Person, regardless of the number of positive diagnoses that an Insured Person may have of Internal Cancer.

☐ **FIRST OCCURRENCE BUILDING BENEFIT RIDER LN-6044-AR**

While this rider is in effect, on the day following each Policy Anniversary, the First Occurrence Benefit amount shown on the Policy Schedule will be increased for each Insured Person by the First Occurrence Building Benefit amount shown on the Policy Schedule. The First Occurrence Building Benefit, if any accrued, will be paid under the same terms and conditions as the First Occurrence Benefit Rider.

This First Occurrence Building Benefit will cease to annually increase for an Insured Person on the day following the first Policy Anniversary after the Insured Person's 65th birthday or on the date of positive diagnosis of Internal Cancer, whichever occurs first. However, regardless of the age of the Insured Person on the Effective Date of this rider, this benefit shall accrue for a period of at least five years unless Internal Cancer is diagnosed prior to the fifth year of coverage. If the Coverage Type shown on the Policy Schedule is "Individual", no further premium will be billed for this rider after the payment of the First Occurrence benefit.

☐ **ANNUAL RADIATION, CHEMOTHERAPY, IMMUNOTHERAPY and EXPERMENTAL TREATMENT BENEFIT RIDER LN-6045-AR**

While this rider is in effect, We will pay the Actual Charge incurred in any one Calendar Year by an Insured Person for Radiation Treatment, Chemotherapy, Hormonal Therapy or Immunotherapy or Experimental Treatment not to exceed the Radiation Treatment, Chemotherapy, Immunotherapy or Experimental Treatment Benefit amount shown on the Policy Schedule for each Calendar Year. The Radiation Treatment, Chemotherapy, Hormonal Therapy, Immunotherapy or Experimental Treatment

must be for the treatment of an Insured Person's Cancer. Treatments must be administered, or in the case of self-administered or oral chemotherapy or immunotherapy, prescribed by a Physician, Chemotherapist, Oncologist, Radiation Therapist or other licensed medical personnel as required by the applicable state law to administer the treatment. Treatment may be on an Inpatient or Outpatient basis. The Radiation Treatment, Chemotherapy, Immunotherapy and Experimental Treatment Benefit amount shown on the Policy Schedule is the maximum We will pay in any one Calendar Year for each Insured Person's Cancer treatments regardless of the number or types of treatments received.

☐ **DAILY RADIATION, CHEMOTHERAPY, IMMUNOTHERAPY and EXPERMENTAL TREATMENT BENEFIT RIDER LN-6046-AR**

While this rider is in effect, We will pay the Actual Charge incurred by an Insured Person, not to exceed the Radiation Treatment, Chemotherapy, Immunotherapy and Experimental Treatment Benefit amount shown on the Policy Schedule for each day an Insured Person receives one or more of the following Cancer treatments:

1. Chemotherapy (including Hormonal Therapy) or Immunotherapy injected by a Chemotherapist,
   an Oncologist, Physician or other legally qualified medical personnel in the office of an Oncologist or Physician, a Chemotherapy Treatment Center, a Hospital or Clinic;
2. Self-injected Chemotherapy or Immunotherapy drugs, limited to the maximum daily benefit amount per treatment.
3. Chemotherapy or Immunotherapy drugs dispensed by a pump or implant. This is limited to the maximum daily benefit amount for the initial prescription and an equal amount for each refill.
4. Oral Chemotherapy or Immunotherapy regardless of where administered. This is limited to the maximum daily benefit amount per prescription.
5. Radiation Treatment administered by a Radiation Therapist, an Oncologist, Physician or other legally qualified medical personnel in the office of an Oncologist or Physician, a Radiation Treatment Center, a Hospital or Clinic. Benefits payable for interstitial or intracavitary applications of Radiation Treatments are payable on the day of insertion only and not for each day the Radiation Treatment remains in the body.
6. Experimental Treatment

The Radiation Treatment, Chemotherapy, Immunotherapy Benefit amount shown on the Policy Schedule is the maximum We will pay on any day an Insured Person receives a Chemotherapy, Immunotherapy or Radiation Treatment, regardless of the type or number of different treatments the Insured Person may receive on the same day.

☐ **HOSPTIAL INTENSIVE CARE UNIT BENEFIT RIDER LN-6047-AR**

Subject to all the terms, provisions, conditions, definitions, exclusions, limitations and reductions contained in the rider and the base policy, for covered Intensive Care Unit or Step Down Unit confinements which occur during a Period of Confinement that begins after the Insured Person's Effective Date of coverage We will pay the benefits described in A., B., or C., below. During each Period of Confinement, W e will pay benefits for a maximum of 45 days under A., B., or C.

A. Intensive Care Unit Benefit - We will pay the Daily Hospital Intensive Care Unit Benefit amount shown on the Policy Schedule for each day an Insured Person is confined in an Intensive Care Unit as the result of Sickness or Injury, subject to the following: (1) Intensive Care Unit Benefits will begin on the first day of such confinement. (2) However, We will not pay benefits for any more than 45 days during any one Period of Hospital Intensive Care Unit Confinement.

B. Double Intensive Care Unit Benefit - The Daily Hospital Intensive Care Unit Benefit payable for any one Period of Confinement that is the result of Cancer or as the result of a Travel Related Injury will be double the Hospital Intensive Care Unit Benefit shown on the Policy Schedule. The double benefit for a Travel Related Injury is payable only for the initial Intensive Care Unit confinement that commences within 24 hours of the accident causing the Travel Related Injury. Double benefits are not payable for successive periods of Intensive Care Unit confinement, even when part of the same Period of Confinement.

C. Step Down Unit Benefit - We will pay one-half of the Daily Hospital Intensive Care Unit Benefit

shown on the Policy Schedule for each day the Insured Person is confined in a Step Down Unit as the result of Sickness or Injury.

Additional Exclusions and Limitations - Coverage under the rider is subject to the applicable Exclusions and Limitations of the base policy to which it is attached. The following additional Exclusions, Reduction and Limitations also apply.

On the date an Insured Person attains Age 75, and continuing thereafter, his or her Daily Hospital Intensive Care Unit benefit will be reduced to an amount equal to one-half of the Daily Hospital Intensive Care Unit Benefit shown on the Policy Schedule.

The rider does not cover Intensive Care Unit or Step Down Unit confinements that are the result of (1) intentionally self-inflicted injury, or (2) the Insured Person being intoxicated or under the influence of alcohol, drugs or any narcotic, unless administered on and according to the advice of a Medical Practitioner.

☐ **SURGICAL BENEFITS RIDER LN-6048-AR**

We will pay a Surgical Expense Benefit for a surgical procedure for the treatment of Cancer (except Skin Cancer) according to the Surgical Schedule shown in the rider. The surgery may be performed either as an inpatient of a Hospital or as an outpatient in a Hospital, Ambulatory Surgical Center, Physician's office or other free standing medical facility. The following rules apply to the Surgical Schedule shown in the rider:

1. Two or more surgical procedures performed at the same time and through the same incision will be deemed one surgery, the surgery with the highest Surgical Benefit.
2. The procedures listed in the Surgical Schedule are selected examples from a complete surgical schedule used by Us. For any surgical procedure not listed in the Surgical Schedule, We will pay a benefit according to the complete schedule. However, in no event will the amount payable exceed the Maximum Benefit amount shown on the Policy Schedule. The complete Surgical Schedule is incorporated into the rider by reference and is available upon request.
3. One unit of coverage under this benefit provides a maximum benefit Amount of $1,000. The amounts shown in the rider provide examples of benefits as they would be payable under the Surgical Schedule. The maximum Surgical Benefit amount for Your coverage under the rider will be shown on the Policy Schedule.
4. We will not pay more than the Actual Charge for any surgical procedure.

Anesthesia Expense Benefit - When a surgical procedure is performed that is a covered surgical expense and the Insured Person incurs charges for anesthesia, We will pay the Actual Charge for the anesthesia not to exceed an amount equal to 25% of the covered Surgical Expense Benefit for the operation performed. This includes the services of a professional anesthesiologist or of an anesthetist under supervision of a Physician for the purpose of administering anesthesia.

Skin Cancer Surgery Expense Benefit - When there is a positive diagnosis of Skin Cancer of an Insured Person and a cutting surgical procedure is performed to remove the positively diagnosed Skin Cancer, We will pay the Actual Charge, not to exceed the amount shown below, for such surgical removal. This benefit is payable in lieu of any benefits for surgical expense and anesthesia expense which are not applicable to Skin Cancer.

Biopsy	$ 125
Excision of lesion of skin	$ 350
Excision of lesion of skin with flap or graft	$ 750

☐ **SPECIFIED DISEASE BENEFIT RIDER LN-6052-AR**

While coverage is in force, if an Insured Person is first diagnosed with one or more covered Specified Diseases and is hospitalized for the definitive treatment of any covered Specified Disease, We will pay benefits according to the provisions of the rider.

Covered Specified Diseases

Addison's Disease	Lyme Disease	Rocky Mountain Spotted Fever
Amyotrophic Lateral Sclerosis	Malaria	Sickle Cell Anemia
Botulism	Meningitis	Tay-Sachs Disease

Bovine Spongiform Encephalopathy	Multiple Sclerosis	Tetanus
Budd-Chiari Syndrome	Muscular Dystrophy	Toxic Epidermal Necrolysis
Cystic Fibrosis	Myasthenia Gravis	Tuberculosis
Diphtheria	Neimann-Pick Disease	Tularemia
Encephalitis	Osteomyelitis	Typhoid Fever
Epilepsy	Poliomyelitis	Undulant Fever
Hansen's Disease	Q Fever	West Nile Virus
Histoplasmosis	Rabies	Whipple's Disease
Legionnaire's Disease	Reye's Syndrome	Whooping Cough
Lupus Erythematosus	Rheumatic Fever	

Initial Hospitalization Benefit - We will pay the Initial Hospitalization Benefit amount shown on the Policy Schedule when an Insured Person is confined to a Hospital for 12 or more hours as a result of receiving treatment for a Specified Disease. This benefit is payable only once per period of confinement and once per Calendar Year for each Insured Person. A period of confinement is a Hospital confinement that starts while the rider is in force. If the confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless it is the result of an entirely different Specified Disease, or unless the confinements are separated by 30 days or more.

Hospital Confinement Benefit - We will pay the Hospital Confinement Benefit amount shown on the Policy Schedule per day when an Insured Person is hospitalized during any continuous period of 30 days or less for the treatment of a covered Specified Disease. Benefits will double per day beginning with the 31st day of continuous confinement.

Exclusions - No benefits will be paid for:

1. loss due to any disease or illness other than those listed as covered Specified Diseases;
2. care and treatment received outside the territorial limits of the United States;
3. treatment that has not been approved by a Physician as being medically necessary; or
4. losses or medical expenses incurred prior to the Effective Date of an Insured Person's coverage regardless of the date of diagnosis.

VII. Premiums - The annual premiums for the coverages outlined above are:

Cancer Policy Only	$_____
Annual Cancer Screening Benefit Rider	$_____
Daily Hospital Confinement Benefit Rider	$_____
First Occurrence Benefit Rider	$_____
First Occurrence Building Benefit Rider	$_____
Annual Radiation, Chemotherapy, Immunotherapy and Experimental Treatment Benefit Rider	$_____
Daily Radiation, Chemotherapy, Immunotherapy and Experimental Treatment Benefit Rider	$_____
Hospital Intensive Care Unit Benefit Rider	$_____
Surgical Benefits Rider	$_____
Specified Disease Benefit Rider	$_____
TOTAL	**$**_____

The premium for the coverages outlined above for each _____ month period on the Effective Date is $ _____, when premium payments are by:

- ☐ Payroll Deduction
- ☐ Share Withdrawal
- ☐ Electronic Funds Transfer
- ☐ Direct Bill (No Direct Bill Monthly)

NOTICE OF 30-DAY RIGHT TO EXAMINE POLICY

Within thirty (30) days from receipt of the Policy, You may return it for any reason. If returned, the Policy is void. Any premiums paid on the Policy will be refunded. The Policy may be returned to Us or to the agent who sold the Policy.

SERFF Tracking Number:	*RDWS-126450975*	*State:*	*Arkansas*
Filing Company:	*LifeShield National Insurance Co.*	*State Tracking Number:*	*45429*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002A Dread Disease - Cancer Only*
Product Name:	*LifeShield LN-6040-AR Limited Benefit Cancer Expense*		
Project Name/Number:	*/*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
04/14/2010	Form	Limited Ben Cancer Expense Policy	04/28/2010	LN-6040-AR.pdf (Superceded)
01/11/2010	Supporting Document	Application	04/28/2010	LN-6049-AR.pdf (Superceded) LN-6050-AR.pdf (Superceded)

LifeShield National Insurance Company®

Administrative Office: 815 West Ash Ave., Duncan, OK 73533 Toll Free: 1-800-366-8354

LIMITED BENEFIT CANCER EXPENSE POLICY

This Policy offers Limited Benefit Supplemental Health Insurance Coverage.

GUARANTEED RENEWABLE FOR LIFE

Except for fraud or material misrepresentation, the Named Insured has the right to renew this Policy for his or her lifetime, as long as premiums are paid on time. This Policy will terminate on the last day of the period for which premium is paid unless continued in force during a Grace Period. We reserve the right to change premiums.

PREMIUMS SUBJECT TO CHANGE ON RENEWAL

On any premium due date after the first Policy Anniversary, We may change the premium rates for this policy only if We also change the rates for all other policies issued in the same Rating Class. We must give 60 days advance written notice of any premium change. No change in the premiums will be made because of the number of claims an Insured Person files nor because of a change in an Insured Person's health.

PART A. INSURING CLAUSE

LifeShield National Insurance Company (herein referred to as We, Us or Our) agrees with the Named Insured (herein referred to as You, or Your) to cover each Insured Person identified in the Policy and any attached riders, amendments, endorsements or applications for any covered loss described in this Policy in return for payment of premiums and subject to the provisions, limitations and exclusions that follow. This Policy is executed as of the Policy Effective Date as shown on the Schedule Page and from which anniversary dates are measured. This Policy takes effect at 12:01 A.M. Standard Time on the Policy Effective Date at the address of the Named Insured.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

The issuance of this Policy is based upon Your answers to the questions on the application. A copy of the application is attached to this Policy. If Your answers are materially incorrect or untrue, We may have the right to deny benefits or rescind this Policy, subject to the Time Limit on Certain Defenses provision. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, please contact Us at this address: 815 West Ash Ave., Duncan, OK 73533.

NOTICE OF 30-DAY RIGHT TO EXAMINE POLICY

Within thirty (30) days from receipt of this Policy, You may return it for any reason. If returned, this Policy is void. Any premiums paid on the Policy will be refunded. This Policy may be returned to Us or to the agent who sold this Policy.

THIS IS A LIMITED BENEFIT POLICY - READ IT CAREFULLY!
NO BENEFITS WILL BE PROVIDED DURING THE FIRST TWO YEARS IMMEDIATELY FOLLOWING THE POLICY EFFECTIVE DATE FOR ANY CLAIMS RESULTING FROM PRE-EXISTING CONDITIONS.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare please review the "Guide to Health Insurance for People with Medicare" which is available from the company.

This Policy is governed by the laws of the state in which it was issued and delivered.

Signed for Us on the Policy Date.

Secretary

President

TABLE OF CONTENTS

POLICY SCHEDULE

Named Insured:	[John Doe]	
Policy Number:	[1234567]	
Policy Effective Date:	[September 1, 2006]	
Coverage Type:	[Individual] [Single Parent] [Family]	
Premium Payment Class:	[Payroll] [Direct]	
Coverage	**Maximum Benefit Amount**	**Annual Premium**
Base Policy	Base Policy Benefits	$[XXX]
Benefit Provision Amendment		[Included in Base Policy]
Optional Benefit Riders		
Annual Cancer Screening Benefit Rider	[$25, $50, $75, $100, $125] Per Calendar Year	$[XXX]
First Occurrence Benefit Rider	[$500, $1,000, $1,500, $2,000, $2,500, $3,000, $3,500, $4,000, $4,500, $5,000, $5,500, $6,000, $6,500, $7,000, $7,500, $8,000, $8,500, $9,000, $9,500, $10,000] Lifetime Maximum	$[XXX]
Surgical Benefits Rider	[$500, $1,000, $1,500, $2,000, $2,500, $3,000, $3,500, $4,000, $4,500, $5,000, $5,500, $6,000, $6,500, $7,000, $7,500, $8,000, $8,500, $9,000, $9,500, $10,000] Per Schedule	$[XXX]
Daily Hospital Confinement Benefit Rider	[$100, $150, $200, $250, $300, $350, $400, $450, $500, $550, $600] Per Day	$[XXX]
Annual Radiation Treatment, Chemotherapy, Immunotherapy and Experimental Treatment Benefit Rider	[$2,500, $5,000, $7,500, $10,000, $12,500, $15,000, $17,500, $20,000] Per Calendar Year	$[XXX]
Daily Radiation Treatment, Chemotherapy, Immunotherapy and Experimental Treatment Benefit Rider	[$200, $300, $400, $500, $600, $700, $800, $900, $1,000] Per Day	$[XXX]
First Occurrence Building Benefit Rider	$100, $200, $300, $400, $500, $600] Per Year	$[XXX]
Hospital Intensive Care Unit Benefit Rider	[$100, $150, $200, $250 $300, $350 $400, $450, $500, $550, $600, $650, $700, $750, $800, $850, $900, $950, $1,000] Per Day	$[XXX]
Specified Disease Benefit Rider **Initial Hospitalization Benefit** **Hospital Confinement Benefit**	 $ 1,500 Per Calendar Year $ 300 per Day for 1st 30 days $ 600 per Day for 31 or more days of continuous confinement	$[XXX]
Premium Mode: [Monthly]	**Total Annual Premium Amount:** **Total Modal Premium Amount:**	$ $

PART B. DEFINITIONS

When We use the following words, this is what We mean:

"Actual Charge" means the amount actually paid by or on behalf of the Insured Person and accepted by a provider for services provided. The amount the Insured Person is legally required to pay the provider for the covered services would be considered the Actual Charge. The negotiated fee, if any, between a managed care organization including but not limited to a preferred provider organization or Medicare would be considered the Actual Charge.

"Age" means Age last birthday of an Insured Person.

"Ambulatory Surgical Center" means a facility, within the United States, primarily licensed to provide elective or Outpatient surgical care and discharges each patient within the same working day. An Outpatient surgical unit of a Hospital also meets this criteria.

"Applicant" means the person first named as applicant in the application for insurance under this Policy.

"Application" means that document, signed by You, containing Your answers to Our questions and Your representations, which We accepted in good faith as being true, complete and correct, to the best of Your knowledge and belief. Your Application is the basis upon which We issued this Policy and it is attached to and made a part of the Policy.

"Audiologist" means anyone, other than an Immediate Family Member, who is licensed and certified to provide therapy to the hearing impaired.

"Calendar Year" means a period of 12 consecutive months starting on January 1 and ending on December 31 of the same year.

"Cancer" means a disease manifested by the presence of a malignant tumor that is characterized by the uncontrolled growth and spread of malignant cells that invade tissue, blood or the lymphatic system. This includes leukemia, Hodgkin's Disease, lymphoma, carcinoma, sarcoma or malignant tumor. Cancer also means Cancer In Situ, a malignant tumor that is confined to the site of origin, the cells of which have not invaded surrounding tissue. Cancer does not include other conditions which may be considered precancerous, including but not limited to, leukoplakia, actinic keratosis, carcinoid, hyperplasia, polycythemia, nonmalignant melanoma, moles or similar disease or lesions.

Such Cancer must be positively diagnosed by a Physician certified by the American Board of Pathology or the Osteopathic Board of Pathology to practice Pathologic Anatomy; and such diagnosis is on the basis of microscopic examination of fixed tissue or preparations from the blood system (either during life or post mortem).

The diagnosis of Cancer must be based solely on the criteria of malignancy established by the American Board of Pathology. Clinical diagnosis of Cancer will be accepted as evidence that Cancer exists in a Covered Person when a pathological diagnosis cannot be made, provided such medical evidence substantially documents the diagnosis of Cancer and the Covered Person receives treatment for Cancer.

"Cancer Treatment Center" means a Chemotherapy Treatment Center or Radiation Treatment Center.

"Charity Hospital" means a Hospital which, in the absence of insurance, does not normally make a charge for its services.

"Chemotherapy" means a drug that: (a) it modifies, destroys, slows the growth, or prevents the spread or recurrence of Cancer cells; and (b) it is approved by the United States Food and Drug Administration to treat Cancer in humans.

"Chemotherapist" means a person who is licensed to administer Chemotherapy or Immunotherapy drugs in the State where such drugs are administered to the Insured Person.

"Chemotherapy Treatment Center" means a Clinic or Outpatient section of a Hospital specializing in the treatment of Cancer with Chemotherapy or Immunotherapy on an Outpatient basis. It must be licensed by the State in which it operates.

"Clinic" means a place operating under the applicable state law or licensing requirements where specialized medical treatment is given.

"Colony Stimulating Factor" means substances that stimulate the production of blood cells or platelets. They must be approved by the United States Food and Drug Administration for use in human Cancer patients being treated with Radiation Treatment, Chemotherapy, or Immunotherapyany. Colony Stimulating Factors include, but are not limited to, granulocyte colony stimulating factors and granulocyte-macrophage colony stimulating factors, erythropoietin, epoetin alfa, darbepoetin, filgrastim, pegfilgrastim and sargramostin.

"Common Carrier" means only the following: commercial airline, passenger train, or bus line between cities. It does not include: taxis, city bus lines, or private charter airplanes.

"Convalescent Care Facility" means an institution that:

(a) is legally operated to provide care and treatment to sick and injured persons at their expense;
(b) is primarily engaged in providing skilled care under the supervision of a Physician during a period of convalescence for sickness or injury;
(c) provides 24-hour nursing services by or under the supervision of Registered Nurses on duty or call; and
(d) maintains a medical record of each patient.

Convalescent Care Facility **does not mean** a home or facility that is used primarily for rest; or provides care and treatment for drug addicts, alcoholics or the mentally ill; or primarily provides custodial or educational care**.**

"Date of Diagnosis" means the later of:

(a) the day the tissue specimen is taken;
(b) the day the definitive diagnostic test is performed that confirms a positive diagnosis when preformed by a Pathologist; or
(c) the day the Positive Diagnosis of Cancer or one of the listed Specified Diseases is pronounced when a clinical diagnosis is made.

"Dependent" means any of the following persons:

1. Your lawful spouse; and
2. any unmarried child, stepchild or adopted child of Yours who has not attained the age of 25, and is:
   (a) under 25 years of age on the date of application; or
   (b) born after the date of application and any applicable additional premium is paid before the 32nd day after the child's birth; or
   (c) adopted by You or who becomes Your stepchild before that child's 25th birthday; and
3. A child for whom You are required to provide insurance under a medical support order or an order enforceable by a court; and
4. Any unmarried child of your child if such child is younger than 25 years of age and is dependent on you for federal income tax purposes at the time of application for coverage of the child.

If You are a party in a suit in which the adoption of the child is sought by You, that child will be deemed to be "adopted". Also, if You become a legal guardian of a foster child, that child will be treated as an adopted child so long as: You continue as the child's legal guardian; the child is living with You and is dependent upon You for support; and all other requirements of the policy are met.

"Divorce/Divorced" means annulment or the dissolution of marriage.

"Effective Date" means the date an individual Insured Person's coverage begins under the Policy and is the latest of: (1) the Policy Effective Date as shown on the schedule page; or (2) the date shown on the endorsement or amendment adding the Insured Person to coverage under the Policy.

"Eligible Family Member" means a person for whom You furnish satisfactory Evidence of Insurability who is either Your spouse or a dependent child.

"Evidence of Insurability" means a statement of a Proposed Insured's medical history which We will use to determine if he or she is approved for coverage. Evidence of Insurability will be provided at Your expense.

"Experimental Treatment" means chemotherapy, or immunotherapy drugs not yet approved by the United States Food and Drug Administration for the treatment of Cancer which are the subject of ongoing clinical studies sponsored and funded by the National Cancer Institute to determine their toxicity, safety, efficacy or their efficacy compared to standard means of treatment. Treatment must be received in the United States or its territories and administered by an Oncologist as defined in this Policy. The Oncologist must certify, to the best of his or her knowledge and belief, that no other treatment having United States Food and Drug Administration approval is superior to the proposed Experimental Treatment.

"Government Hospital" means a hospital operated by or for an agency of the United States Government.

"Home Health Care" means the care and treatment of an Insured Person at his or her place of residence. Home Health Care is provided only if hospitalization or confinement in a Convalescent Care Facility would otherwise have been required. A plan establishing the necessary Home Health Care Services must be approved in writing by the attending Physician. Home Health Care Services must be provided by an agency that meets the qualifications set out below.

"Home Health Care Agency" means entity licensed to provide Home Health Care Services under applicable state law, or, in the absence of such state law, an entity that meets the following requirements:

(a) it must be primarily engaged in providing Home Health Care Services;
(b) its policies must be established by a group of professional personnel, including at least one Physician and one Registered Nurse;
(c) supervision of Home Health Care Services must be performed by a Physician or Registered Nurse;
(d) it must maintain clinical records on all patients;
(e) it must have a full time administrator.

"Home Health Care Services" means:

(a) part-time or intermittent home nursing care provided by or under the supervision of a Registered Nurse;
(b) part-time or intermittent home health aide services that consists primarily of caring for the patient; and
(c) medical supplies and equipment suitable for home use.

Home Health Care Services **does NOT mean:** (a) services or supplies not included in the Home Health Care plan; (b) services of a person who is an Immediate Family Member; (c) custodial care; (d) services or supplies for personal comfort or convenience; (e) food service or meals; or (f) transportation services.

"**Hormonal Therapy"** means a drug that adds, blocks, or removes hormones to slow, stop the growth of or prevent the recurrence of Cancer cells. It must be approved by the United States Food and Drug Administration to treat Cancer in humans.

"Hospice Center" means a facility that provides short periods of confinement for terminally ill patients. A Hospice Center must operate a program of hospice care that meets the standards set forth by the National Hospice Organization. It must also be directed by a Physician, supervised by a Registered Nurse, and licensed or certified by the state in which it is located.

"Hospice Team" means a team of professionals including a Physician and a Nurse. It may also include a social worker, clergyman, clinical psychologist, physical therapist, or counselor. It must exist primarily to administer a hospice care program meeting the standards of the National Hospice Organization in the patient's home. Care must be available 24 hours a day, seven days a week.

"Hospital" means an institution that:

(a) operates as a Hospital pursuant to law;
(b) operates primarily for the reception, care and treatment of sick or injured persons as Inpatients;
(c) provides 24-hour nursing service by Registered Nurses on duty or on call;
(d) has a staff of one or more Physicians available at all times;
(e) provides organized facilities for diagnosis, treatment and surgery either on its premises or in facilities available to it on a pre-arranged basis.

Hospital **does NOT include** the following: (a) convalescent homes or convalescent, rest or nursing facilities; (b) facilities primarily affording custodial, educational or rehabilitative care; or (c) facilities for the aged, drug addicts or alcoholics.

"Immediate Family Member" means You and Your spouse or the parent, child, brother or sister of You or Your spouse.

"Immunoglobulin" means a protein naturally made by plasma cells in response to an antigen (foreign substance). The protein helps destroy the antigen. For the purposes of this Policy, the protein may be either natural or recombinant but it must be approved by the United States Food and Drug Administration for use in treating Cancer in humans.

"Immunotherapy" means a drug including a biological response modifier, biological therapy or biotherapy. that meets the following criteria: (1) it stimulates or restores the ability of the immune system to modify, destroy or aid in the prevention of the spread of Cancer cells and (2) it is approved by the United States Food and Drug Administration to treat Cancer in humans. Immunotherapy **does NOT include** Immunoglobulin.

"Incapacitated Child" means a Dependent child who becomes incapable of self-support because of physical impairment or mental retardation while an Insured Person and before attaining Age 25 and who is primarily dependent on You or Your spouse for support and maintenance and is unmarried.

"Inpatient" means the Insured Person who is confined in a Hospital using and being charged for daily room and board.

"Insured Person" means You and Your Eligible Family Members whose coverage has become effective and such coverage has not been terminated.

If the Type of Coverage shown on the Policy Schedule is **Individual**, Your Newborn Child or Your Newly Adopted Child will become an Insured Person for a period of 31 days commencing with the moment of birth or adoption. Thereafter the Newly Adopted Child or Newborn Child will be considered a Dependent child who is an Eligible Family Member and insurance will continue past this 31 days only if You give Us written notice of the birth or adoption within the 31 day period and pay the additional premium required.

If the Type of Coverage shown on the Policy Schedule is **Single Parent** or **Family**, Your Newborn Child or Your Newly Adopted Child will become an Insured Person commencing with the moment of birth or adoption. Thereafter the Newborn Child or Newly Adopted Child will be considered a Dependent child who is an Eligible Family Member.

"Internal Cancer" means Cancer that is not a Skin Cancer.

"Local or Locally" means within 30 miles, one way, of the Insured Person's usual place of residence.

"Named Insured" means the person accepted for coverage by Us who has completed and signed the application. This is the person whose name appears on the Policy Schedule as "Named Insured."

"Newborn Child" means any child born to You or Your insured Spouse after the Policy Effective Date.

"Newly Adopted Child" means a child who is: (a) adopted by You after the Policy Effective Date; or (b) a child who has been placed with You after the Policy Effective Date and for whom the application and approval procedures prescribed by law for adoption have been completed.

"Non-Local or Non-Locally" means more than 30 miles, one way, and less than 700 miles, one way, from the Insured Person's usual place of residence.

"Nurse" means any one of the following who is not one of the Insured Person's Immediate Family Members: a graduate Registered Nurse (R.N.); or a Licensed Practical Nurse (L.P.N.); or a Licensed Vocational Nurse (L.V.N.). With respect to the benefits provided under this Policy, Nurse will not include an R.N., L.P.N., or L.V.N. who is employed by the Hospital where the Insured Person is confined.

"Oncologist" means a Physician certified to practice in the field of Oncology.

"Outpatient" means the Insured Person is not confined in a Hospital.

"Pathologist" means a Physician who has been certified by either the American Board of Pathology, the Osteopathic Board of Pathology, or the American Board of Dermatopathology to practice pathological anatomy.

"Period of Hospital Confinement" means the period of consecutive days that the Insured Person is confined as an Inpatient in a Hospital on the advice and recommendation of a Physician. It begins on the date the Insured Person is admitted to the Hospital as an Inpatient and ends on the Insured Person's date of discharge, unless discharge is for the purpose of immediate readmission to another Hospital.

"Physician" means a practitioner of the healing arts, including a nurse practitioner, duly licensed, practicing in the United States and legally qualified to treat sickness or injuries. Such person must not be the Insured Person, an Insured Person's Immediate Family Member or a business associate. He or she must be providing services within the scope of his or her license, and must be a board certified specialist where required by this policy. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible Physicians.

"Policy Anniversary" means the same day and month as the Policy Effective Date shown in the Policy Schedule for each year this policy remains in force.

"Policy Effective Date" means the day on which coverage under the Policy begins and is shown on the Policy Schedule.

"Pre-existing Condition" means Cancer, or a listed Specified Disease if that optional rider is issued, which was diagnosed by a Physician or for which medical consultation, advice or treatment was recommended by or received from or sought from a Physician within five years prior to the effective date of coverage for each Insured Person.

"Proposed Insured" means any person named in Your application for insurance.

"Radiation Treatment" means x-ray therapy, gamma ray therapy, particle beam therapy, proton beam therapy, or intensity-modulated radiation therapy**,** brachytherapy, radioactive isotopes therapy, radioactive iodine, cobalt, palladium, cesium or iridium that is approved by the United States Food and Drug Administration for the treatment of Cancer in humans and is used to modify, destroy, slow the growth or prevent recurrence of Cancer cells. The treatments discussed above must not be used for diagnostic or planning purposes.

"Radiation Treatment Center" means a Clinic or outpatient section of a Hospital specializing in Radiation Treatment of Cancer on an Outpatient basis.

"Radiation Therapist" means a Physician, Nurse or other medical personnel who are licensed to administer external or internal radiation. The medical professional must also be certified by the American Board of Radiology to administer therapeutic radiation.

"Rating Class" means a population segment classified by actuaries as having similar insurance risk characteristics, such as issue age, gender, underwriting classification, benefit category, issue state, and health status of the insured at the time the policy was purchased.

"Renewal Date" means the date any premium after the first premium for this Policy is due.

"Skin Cancer" means basal cell carcinoma, basal cell epithelioma, squamous cell carcinoma, or melanoma of Clark's Level I or II or Breslow level equal to or less than 1.5 mm.

"Tentative Diagnosis" means a diagnosis by a qualified Physician, based on the Physician's experience, training and expertise, when a Positive Diagnosis cannot be made due to medical reasons**.**

"Terminally Ill" means the Insured Person has a life expectancy of 6 months or less.

"Total Disability / Totally Disabled" means that, as a result of Cancer, You are:

(a) unable to perform all of the substantial or material duties of Your regular occupation during the first two years beginning with the commencement of such disability;
(b) unable to engage in any employment or occupation for which You are or become qualified by reason of education, training or experience after the first two years beginning with the commencement of such disability; and
(c) under the care of a Physician.

If 60 days or less separate two periods of Total Disability for the same Cancer, the second will be a continuation of the first.

"We, Our, Us, or Company" means LifeShield National Insurance Company.

"You or Your" means the Named Insured.

PART C. BENEFIT PROVISIONS

We will pay the benefits as described in PART D for the treatment of an Insured Person's Cancer, and if such optional rider is also issued, for the treatment of a listed Specified Disease provided he or she is covered under this Policy and/or rider and this Policy and/or rider remains in force. Payment will be made in accordance with all applicable Policy and/or rider provisions. Benefits are payable for a positive diagnosis that begins more than 30 days after the Effective Date. The positive diagnosis must be for Cancer as defined in this Policy, or for a Specified Disease as defined in the optional rider.

All benefits are subject to terms and conditions of this Policy and/or Specified Disease rider. If Cancer or a listed Specified Disease is diagnosed while You or any Insured Person is confined in the Hospital, benefits will begin on the day of admission or 10 days prior to the date of diagnosis if this is more favorable to You. Admission to the Hospital must begin more than 30 days after the Effective Date of coverage. If a positive diagnosis is made for Cancer or a listed Specified Disease within 12 months after a Tentative Diagnosis, benefits will be paid from the date of the Tentative Diagnosis if the Tentative Diagnosis is made more than 30 days after the Effective Date of coverage**.**

PART D. DESCRIPTION OF BENEFITS

Positive Diagnosis Benefit - We will pay the Actual Charge not to exceed $300 per Calendar Year for one test that confirms the positive diagnosis of Cancer in an Insured Person. This benefit is not payable for multiple diagnoses of the same Cancer or for Cancer that metastasizes or for recurrence of the same Cancer.

National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation / Consultation Benefit - If an Insured Person receives a positive diagnosis of Internal Cancer and seeks an evaluation or consultation at a National Cancer Institute designated Comprehensive Cancer Treatment Center for the purpose of obtaining a treatment option opinion, We will pay the Actual Charge not to exceed a lifetime

maximum of $750. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the Insured Person's place of residence, We will also pay the transportation and lodging expenses incurred not to exceed a lifetime maximum of $350. This benefit is not payable on the same day a Second or Third Surgical Opinion Benefit is payable. This benefit is payable in lieu of the Non-Local Transportation and Lodging Expense Benefits of the Policy. This benefit is payable one time during the lifetime of the Insured Person.

Second and Third Surgical Opinion Expense Benefit – If surgery is recommended for the removal of Cancer, We will pay the Actual Charge for a written second surgical opinion concerning the Cancer surgery. If the second surgical opinion is in conflict with that of the Physician originally recommending the surgery, We will pay the Actual Charge for a written third surgical opinion. The Physician providing the second or third surgical opinion cannot be associated with the Physician who originally recommended the surgery. This benefit is not payable for the same day the National Cancer Institute Evaluation/Consulting Benefit is payable.

Outpatient Hospital or Ambulatory Surgical Center Expense Benefit - We will pay the Actual Charge, not to exceed $350 per day, made by an Ambulatory Surgical Center or Outpatient department of a Hospital for the use of its facilities during the performance of a surgical procedure covered under this Policy.

Medical Imaging, Treatment Planning and Monitoring Expense Benefit - We will pay the Actual Charge not to exceed $1,000 per Calendar Year, for laboratory tests, routine or diagnostic X-rays, scans or medical images and their interpretation when used in the planning or monitoring of external radiation, internal radiation, Chemotherapy or Immunotherapy treatments of Cancer.

Anti-Nausea Medication Expense Benefit - We will pay the Actual Charge for anti-nausea medication not to exceed $150 per Calendar Month when an Insured Person is prescribed such medication as the result of Radiation Treatment, Chemotherapy or Immunotherapy treatments for Cancer.

Colony Stimulating Factor or Immunoglobulin Expense Benefit - We will pay the Actual Charge not to exceed $1,000 per calendar month for Colony Stimulating Factor Drugs or Immunoglobulins prescribed by a Physician or Oncologist during an Insured Person's Cancer treatment regimen for which benefits are payable under the Radiation, Chemotherapy and Immunotherapy Benefit of this Policy or rider attached to it.

Outpatient Blood, Plasma and Platelets Expense Benefit - If, as the result of Cancer, an Insured Person requires blood, plasma, platelets or blood transfusions, on an Outpatient basis, We will pay the Actual Charge not to exceed $300 per day including the costs of procurement, administration, processing and cross matching.

Inpatient Blood, Plasma and Platelets Expense Benefit - If, as the result of Cancer, an Insured Person requires blood, plasma, platelets or blood transfusions, on an Inpatient basis, We will pay the Actual Charge not to exceed $300 per day including the costs of procurement, administration, processing and cross matching.

Bone Marrow Donor Expense Benefit - When an Insured Person receives bone marrow or stem cells from another live person for the purpose of a bone marrow or stem cell transplant in connection with the Insured Person's Internal Cancer treatment, We will pay the Daily Hospital Confinement Benefit amount shown on the Policy Schedule for each day the donor is confined in a Hospital for the harvesting of bone marrow or stem cells used in a covered bone marrow or stem cell transplant.

Bone Marrow or Stem Cell Transplant Expense Benefit - We will pay the Actual Charge not to exceed a lifetime maximum of $15,000 for surgical and anesthesia procedures (including the harvesting and subsequent re-infusion of blood cells or peripheral stem cells) performed for a bone marrow transplant and/or a peripheral stem cell transplant for the treatment of an Insured Person's Internal Cancer**.** This benefit will be paid in lieu of the Surgical Expense Benefit and the Anesthesia Expense Benefit which may be described in a rider attached to this policy.

Inpatient Oxygen Expense Benefit – When an Insured Person is confined to a Hospital for the treatment of Cancer and requires oxygen that is prescribed and ordered by a Physician, We will pay the Actual Charge for the oxygen not to exceed $300 per Hospital confinement.

Attending Physician Expense Benefit - We will pay the Actual Charge not to exceed $ 40 per day for the professional services of a Physician or Oncologist rendered to an Insured Person while he or she is confined in a Hospital for the treatment of Cancer. This benefit is payable only if the Physician or Oncologist personally visits the Hospital room occupied by the Insured Person. The benefit amount stated is the maximum amount payable for each day of Hospital confinement regardless of the number of visits made by one or more Physicians or Oncologists.

Inpatient Private Duty Nursing Expense Benefit - We will pay the Actual Charge not to exceed $150 per day for the full time service of a Nurse that is required and ordered by a Physician when an Insured Person is confined in a Hospital for the treatment of Cancer. The Nurse must provide services other than those normally provided by the Hospital. The Nurse may not be an employee of the Hospital or an Immediate Family Member of the Insured Person.

Outpatient Private Duty Nursing Expense Benefit – Following a period of Hospital confinement of an Insured Person for the treatment of Cancer, We will pay the Actual Charge not to exceed $ 150 per day, limited to the same number of days of the prior Hospital confinement, for the full time service of a Nurse that is required and ordered by a Physician when an Insured Person is confined indoors at home as the result of Cancer. This benefit is not payable if the services of the Nurse are custodial in nature or to assist the Insured Person in the activities of daily living. This benefit is not payable when the Nurse is a member of the Insured Person's Immediate Family.

Home Health Care Expense Benefit - We will pay benefits for the following covered charges when an Insured Person requires Home Health Care for the treatment of Cancer.

1. Home Health Care Visits - We will pay the Actual Charge for Home Health Care Visits not to exceed $ 75 for each day on which one or more such visits occur. We will not pay this benefit for more than 60 days in any Calendar Year.
2. Medicine and Supplies - We will pay the Actual Charge not to exceed $ 450 in any Calendar Year for drugs, medicine, and medical supplies provided by or on behalf of a Home Health Care Agency.
3. Services of a Nutritionist - We will pay the Actual Charge not to exceed a lifetime maximum of $ 300 for the services of a nutritionist to set up programs for special dietary needs.

Convalescent Care Facility Expense Benefit - We will pay the Actual Charge not to exceed $ 100 per day for an Insured Person's confinement in a Convalescent Care Facility. The maximum number of days for which this benefit is payable will be the number of days in the last Period of Hospital Confinement that immediately preceded admission to the Convalescent Care Facility. The Convalescent Care Facility confinement must:

1. be due to Cancer;
2. begin within 14 days after the Insured Person has been discharged from a Hospital for the treatment of Cancer; and
3. be authorized by a Physician as being medically necessary for the treatment of Cancer.

Hospice Care Expense Benefit – When an Insured Person, as a result of Cancer, requires Hospice Care, We will pay the Actual Charge for Hospice Care not to exceed $ 100 per day. This benefit is payable whether confinement is required in a Hospice Center or services are provided in the Insured Person's home by a Hospice Team. Eligibility for benefit payments will be based on the following conditions being met: (1) the Insured Person has been given a prognosis of being Terminally Ill with an estimated life expectancy of 6 months or less; and (2) We have received a written summary of such prognosis from the attending Physician. We will not pay this benefit while the Insured Person is confined to a Hospital or Convalescent Care Facility. The lifetime maximum benefit is 365 days of Hospice Care.

Non-Local Transportation Expense Benefit - We will pay the Actual Charge for Non-Local transportation not to exceed coach fare by on a Common Carrier for the Insured Person and one adult companion's travel to a Hospital, Radiation Therapy Treatment Center, Chemotherapy Treatment Center, Oncology Clinic or any other specialized treatment center where the Insured Person receives treatment for Cancer. This benefit is payable only if the treatment is not available Locally but is available Non-Locally. The adult companion may include the live donor of bone marrow or stem cells used in a bone marrow or stem cell transplant for the Insured Person. At the option of the Insured Person, We will pay a single private vehicle mileage allowance of 50 cents per mile for Non-Local transportation in lieu of the common carrier coach fare.

Lodging Expense Benefit - When an Insured Person receives treatment for Cancer at a Non-Local Hospital, Radiation Therapy Treatment Center, Chemotherapy Treatment Center, Oncology Clinic or any other specialized treatment center, We will pay the Actual Charge not to exceed $ 75 per day for a room in a motel, hotel or other appropriate lodging facility (other than a private residence). The room must be occupied by the Insured Person or an adult companion, which may include the live donor of bone marrow or stem cells used in a bone marrow or stem cell transplant for the Insured Person. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment, nor for lodging expense incurred more than 24 hours following treatment. This benefit is limited to 100 days per Calendar Year.

Ambulance Expense Benefit - We will pay the Actual Charge for ambulance service if an Insured Persons is transported to a Hospital where he or she is admitted as an Inpatient for the treatment of Cancer. The ambulance service must be provided by a licensed professional ambulance company or an ambulance owned by the Hospital.

Prosthesis Expense Benefit:
(a) Surgically Implanted Breast Prosthesis – If, as the result of breast removal due to Cancer, the attending Physician prescribes a breast prosthesis to restore normal body contour, We will pay the Actual Charge for the prosthesis and its implantation. This benefit does not include coverage for breast reconstruction surgery which may be covered under the Surgical Schedule within the Surgical and Anesthesia Benefits Rider, if such rider is issued as part of this policy.
(b) Non-Surgically Implanted Prosthesis – If an Insured Person sustains an amputation, as the result of treatment for Cancer, and an artificial limb or other non-surgically implanted prosthetic device is required and prescribed by a Physician to restore normal body function, We will pay the Actual Charge not to exceed a lifetime maximum of $ 2,000 per such amputation. The cost for the replacement of a prosthetic device is not covered. Hairpieces or wigs are not covered under this benefit.

Hairpiece Expense Benefit – If an Insured Person suffers hair loss due to Cancer treatments, We will pay the Actual Charge not to exceed a lifetime maximum of $150 for the purchase of a wig or hairpiece.

Rental or Purchase of Medical Equipment Expense Benefit – If, as the result of Cancer, the attending Physician prescribes covered medical equipment designed for home use, We will pay the lesser of the Actual Charge for the rental or purchase of such medical equipment not to exceed $1,500 per Calendar Year. Covered medical equipment includes wheel chair, oxygen equipment, respirator, braces, crutches or hospital bed.

Physical, Speech, Audio Therapy and Psychotherapy Expense Benefit - We will pay the Actual Charge not to exceed $ 25 per therapy session for:

1. Physical therapy treatments given by a licensed Physical Therapist, or
2. Speech therapy given by a licensed Speech Pathologist/Therapist; or
3. Audio therapy given by a licensed Audiologist; or
4. Psychotherapy given by a licensed Psychologist.

These therapy sessions may be given at an institute of physical medicine and rehabilitation, a Hospital, or the Insured Person's home. These treatments must be given on an Outpatient basis, unless the primary purpose of a Hospital confinement is for treatment of Cancer other than with physical, speech or audio therapy or psychotherapy. Benefits under this section may not exceed $1,000 per Calendar Year.

Waiver of Premium Benefit - We will waive the premiums starting on the first premium due date following a 60 day period of Total Disability of the Named Insured due to Cancer. The Named Insured must: (1) be receiving treatment for such Cancer for which benefits are payable under this Policy; and (2) remain disabled for 60 consecutive days. We will waive premiums for as long as the Named Insured remains Totally Disabled. Premiums will be waived in accordance with the mode of payment in effect when treatment began.

Totally Disabled means the Named Insured is:

(1) unable to work at any job for which he or she is qualified by education, training or experience; and
(2) under the care of a Physician for the treatment of internal Cancer.

If the Named Insured is retired or Age 65 and over at the time he or she becomes Totally Disabled, the definition of Total Disability will mean the inability to perform two (2) or more of the ADL's (Activities of Daily Living) listed below without the assistance of another person. ADL's are defined as activities used in measuring levels of personal functioning capacity. Normally, these activities are performed without assistance, allowing personal independence in everyday living. The ADL's are:

1. Transferring - moving between the bed and a chair or the bed and a wheelchair;
2. Dressing - putting on and taking off all necessary items of clothing;
3. Toileting - getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene;
4. Eating - all major tasks of getting food into the body;
5. Bathing - getting into or out of the tub or shower and otherwise washing the parts of the body.

We may ask for and use an independent consultant to determine whether the Named Insured can perform an ADL when this benefit is in force.

PART E. EXCLUSIONS AND LIMITATIONS

No benefits will be paid for

1. any loss due to any disease or illness other than Cancer;
2. care and treatment received outside the territorial limits of the United States;
3. treatment by any program engaged in research that does not meet the criteria for Experimental Treatment as defined;
4. treatment that has not been approved by a Physician as being medically necessary; or
5. losses or medical expenses incurred prior to the Effective Date of an Insured Person's coverage regardless of the Date of Positive Diagnosis.

Pre-Existing Condition(s) Limitation
The benefits of this policy will not be payable during the first 24 months that coverage is in force with respect to an Insured Person for a loss caused by a Pre-Existing Condition disclosed or not disclosed on the application. This 24-month period is measured from the effective date of coverage for each Insured Person.

PART F. PREMIUMS

Coverage is in consideration of and subject to payment of the first premium. An Insured Person’s first premium and premium payment mode is shown on the Policy Schedule. Subsequent premiums are due and payable on the premium due date.

Premium Payment Class - The Premium Payment Class for this Policy is shown on the Policy Schedule.

a. **Payroll** means that premiums for this Policy, on the Policy Effective Date, are withheld through payroll or share account deductions and remitted to Us by an employer or other third party.
b. **Direct** means premiums are remitted directly to Us by You through electronic funds transfer or by mail.

Grace Period - We grant a grace period of 31 days for each premium payment due after the first premium payment. Coverage remains in force during the grace period unless You have given Us written notice of Your request for cancellation.

Reinstatement - If the renewal premium is not paid before the Grace Period ends, the Policy will lapse. Later acceptance of the premium by Us without requiring an application for reinstatement will reinstate this Policy. If We require an application, the Named Insured will be given a receipt for the premium. If the application is approved, the Policy will be reinstated as of the approval date. Lacking that approval, the Policy will be reinstated on the 45th day after the date of the receipt unless We have previously written the Named Insured of its disapproval. The reinstated Policy will cover only loss that results from a covered disease that starts more than 10 days after the date of reinstatement. In all other respects, the Named Insured’s rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated Policy.

PART G. TYPES OF COVERAGE

The Type of Coverage issued is shown on the Policy Schedule.

1. **Individual** means that only the Named Insured shown on the Policy Schedule is covered.
2. **Single Parent** means that only the Named Insured and Dependent Child(ren) who is/are also Eligible Family Members are covered.
3. **Family** means that the Named Insured and all Eligible Family Members are covered.

PART H. TERMINATION OF COVERAGE

If We accept premium for coverage extending beyond the date, age, or event specified for termination of an Insured Person, then coverage of such person shall continue during the period for which such premium was accepted. This does not apply where such acceptance was based on a misstatement of age.

Individual Terminations - Your coverage under this Policy will terminate on the earliest of:

(a) the date of expiration of the Grace Period during which any premium due remains unpaid;
(b) the date You specify in Your written request for termination.

Any other Insured Person's coverage under this Policy will terminate on the earliest of:

(a) the date Your coverage terminates;
(b) the date he or she is no longer an Eligible Family Member;
(c) the date of expiration of the Grace Period during which any premium due for the Insured Person remains unpaid; or
(d) the date You specify in Your written request to terminate coverage for the Insured Person.

Time of Termination - Termination of coverage takes effect at 12:01 A.M. Standard Time at Your place of residence on the date of termination.

Pending Claims - Termination of coverage will not affect a claim for a covered loss that occurred while coverage was in force under this Policy.

Adjustment of Premium - If Your Coverage Type changes because of the termination of coverage of an Insured Person, and the change is to a type that has a lower premium, premiums becoming due following the date of change will be adjusted accordingly.

PART I. CONTINUATION OF COVERAGE

Continuation of Coverage for Incapacitated Child - An Incapacitated Child will continue as an Insured Person so long as he or she continues to meet the definition of an Incapacitated Child, any required premium is paid and You continue to be insured. The Incapacitated Child will be deemed to have ceased to qualify as an Insured Person if:

(a) We ask You for proof of his or her current status; and
(b) You fail to give Us proof within 31 days after the date of our request. We may ask You to give Us proof of the Incapacitated Child's status as often as We deem necessary. We will not ask You to give Us proof more frequently than once a year after the Incapacitated Child's coverage has been extended for two years beyond the limiting age. You will be liable for payment of the premium required to continue coverage of an Incapacitated Child.

Continuation of Coverage If You Die - If You die, Your Spouse will replace You as the Named Insured. However, if Your Spouse is not an Insured Person at that time, coverage will end for all Insured Persons.

PART J. CONVERSION

Divorced Spouse Conversion - If the spouse's coverage under this Policy would terminate because of his or her divorce from the Named Insured, We agree to issue a new Policy to the spouse. The spouse must request the new policy and pay the required premium within 60 days of the divorce. Other dependents covered under this Policy may be covered under the new policy or under this Policy as the Named Insured and his or her spouse elect. They may not be covered under both policies. If either this Policy or a new policy is in force on the Named Insured or his or her divorced spouse and either remarries, such new spouse may be covered under the appropriate policy. We must be advised of the remarriage by the completion of a new Application for the new spouse. This new Application is subject to Evidence of Insurability satisfactory to Us.

Child Conversion - A Dependent Child who is no longer an Eligible Family member due to marriage or the loss of Dependent status and who desires to continue coverage as a Named Insured under separate coverage may do so by notifying Us of the request in writing. The child will have the right to continue coverage as the Named Insured with separate similar coverage without Evidence of Insurability and with no interruption in coverage provided We receive written notification of the request prior to sixty (60) days after the marriage or the loss of dependent status.

PART K. HOW TO FILE A CLAIM

Notice of Claim - Written notice of claim must be received by Us within 30 days after an Insured Person's loss, or as soon thereafter as reasonably possible. Written notice given by or on behalf of the claimant to Us with information sufficient to identify the Insured Person, is deemed notice to Us. The written notice should include the Insured Person's name and the Policy number.

Claim Forms - When We receive the notice of claim, We will send the claimant forms for filing proof of loss. If these forms are not sent to the claimant within 15 days, the claimant will be deemed to have met the proof of loss requirement by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

Proof of Loss - We must receive written proof of loss within 90 days after it occurs or as soon thereafter as reasonably possible. Proof of loss includes any documentation necessary to establish that a benefit is payable. Proof of loss also includes, but is not limited to, explanation of benefits from other coverage of the Insured Person, if any, and any other documentation necessary to determine Actual Charges. Proof of loss would also include documentation showing the amount the Insured Person is legally required to pay the provider for the covered treatments. Proof provided more than one year late will not be accepted, unless the Insured Person had no legal capacity in that year.

PART L. TIME OF PAYMENT OF CLAIMS

All benefits payable under this policy for any loss, other than loss for which this policy provides any periodic payment, will be paid within thirty-five (35) days after receipt of due written proof of such loss in the form of clean claim.

Benefits due under the policy and claims are overdue if not paid within thirty-five (35) days after We receive a clean claim containing necessary medical information and other information essential for Us to administer preexisting conditions and determine Actual Charges.

A **"clean claim"** means a claim We receive for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the insured in order to be processed and paid by Us. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. A clean claim does not include any of the following:

(a) A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;
(b) Claims which are submitted fraudulently or that are based upon material misrepresentations;

(c) Claims that require information essential for Us to administer preexisting conditions or determine Actual Charges; or
(d) Claims submitted by a provider more than thirty (30) days after the date of service; if the provider does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the insured.

Not later than thirty-five (35) days after the date We receive a claim, We shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider or the insured of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by Us shall be paid within twenty (20) days after receipt.

PART M. PAYMENT OF CLAIMS

Upon receipt of due written proof of loss, payments for all losses will be made to the Named Insured. If the Named Insured dies before all payments due have been made, the amount still payable will be paid to the Named Insured's estate.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding $1,000 per month may be made, at Our option, to any relative by blood or connection by marriage of the payee, who has submitted reliable documentary evidence and, in Our opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs. Any payment We make in good faith fully discharges Our liability to the extent of the payment made.

If the Named Insured provides Us with a written release to do so, we may, at Our option, pay benefits directly to the institution or person rendering treatment or services covered under this Policy.

Unpaid Premium- When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

PART N. GENERAL PROVISIONS

Entire Contract; Changes - This Policy, the Application, and any attached riders or amendments make up the entire contract. A copy of the Application is attached. In the absence of fraud, all statements made on the Application will be considered representations and not warranties. No written statement made by the Named Insured will be used in any contest unless a copy of the statement is furnished to the Named Insured or his or her personal representative. No change in this Policy will be valid until approved by an officer of the Company. The change must be signed by an officer of the Company and attached to this Policy. No agent may change this Policy or waive any of its provisions. .

Time Limit on Certain Defenses- After two years from the date a person becomes insured under this Policy, We cannot use misstatements, except fraudulent misstatements, in the Application to void coverage or deny a claim for loss that happens after the two-year period.

No claim for loss incurred after two years from the date a person becomes insured under this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description existed prior to the effective date of such person's insurance.

Physical Examination - We, at Our own expense, have the right to have the person of any individual whose loss is the basis of claim under this Policy examined when and as often as We may reasonably require during the pendency of the claim.

Legal Actions - No action at law or in equity may be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Noncompliance with Policy Requirements - Any express waiver by Us of any requirements of this Policy will not constitute a continuing waiver of such requirements. Any failure by Us to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

Conformity with State Statutes - Any provision of this Policy which, on its Policy Effective Date, is in conflict with the statutes of the state in which this Policy is issued and delivered is hereby amended to conform to the minimum requirements of those statutes.

Clerical Error - Clerical error, whether by You or Us, will not void the insurance of any Insured Person if that insurance would otherwise have been in effect or extend the insurance of any Insured Person if that insurance would otherwise have ended or been reduced as provided in this Policy.

Assignment - You may assign all of Your rights, privileges and benefits under this Policy to the institution or person rendering the service as allowed in the Payment of Claims provision. We are not bound by an assignment until We receive and file a copy of the assignment containing the Named Insured's signature. We are not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of this Policy.

Misstatement of Age - If premiums for the Insured Person are based on age and the Insured Person's age has been misstated, there will be a fair adjustment of premiums based on his or her true age. If the benefits for which the Insured Person is insured are based on age and the Insured Person's age has been misstated, there will be an adjustment of said benefit based on his or her true age. We may require satisfactory proof of age before paying any claim.

Termination of an Insured Person - Upon the termination of coverage of an Insured Person, the premium on this Policy shall be the applicable premium for the remaining Insured Persons.

Refund of Unearned Premium - If a Insured Person dies, any premium paid to Us on behalf of the deceased for a period after the date of such death will be refunded on a pro-rata basis. Notice of death should be sent to Us within 12 months, or as soon as reasonably possible, after an Insured Person has died.

LifeShield National Insurance Company®
Administrative Office: 815 West Ash Ave., Duncan, OK 73533 Toll Free: 1-800-366-8354
Application Form for Cancer Insurance and Optional Riders
Application Form for Accident Expense Coverage

PAYROLL APPLICATION FORM
Requested Effective Date_____

Employer		Group Number		Billing Mode ☐ M ☐ SM ☐ BW ☐ W ☐ Other _____	
Applicant Proposed for Insurance (First, MI, Last)		S. S. Number		Employee Number	
☐ Emp ☐ Spouse ☐ Child ☐ Other	☐ Male ☐ Female	Age	Birth Date	Home Phone Number	
Home Address		City	State	Zip	
Job Title/Occupation	Do you normally work 20 or more hours per week for the Employer listed above? ☐ Yes ☐ No		State of Birth	Date Hired	
☐ Payor or ☐ Owner (if other than Proposed Insured) & Address		S.S. Number or Tax ID Number		Birth Date	
Primary Beneficiary - Full Name - Age - Relationship		Contingent Beneficiary - Full Name - Age - Relationship			

DEPENDENTS PROPOSED FOR INSURANCE

	Full Name	Sex		Birth Date
Spouse		☐ M	☐ F	
Children		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	

INSURANCE APPLIED FOR

Cancer Insurance (Includes Base Policy)	ASCB	FOB	FOBB*	RCIB required	SB	DHCB	SDB	ICUB	Modal Premium
☐ Individual ☐ One Parent ☐ Family	$_____ Per year	$_____ Lifetime maximum	$_____ Per year	$_____ ☐ Annual ☐ Daily	$_____ Per schedule	$_____ Per day	$_____ Per day	$_____ Per day	$
Accident Expense ☐ Individual ☐ One Parent ☐ Husband/Wife ☐ Family	☐ Plan A ☐ Plan B								$
Section 125 ☐ Yes ☐ No								**TOTAL MODAL PREMIUM**	**$**

MEDICAL QUESTIONNAIRE

1.	Are you actively at work now for the named employer and have you worked at least 20 hours each week performing all duties of your regular occupation at your regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?	☐ Yes ☐ No
2.	Within the past five years, has any person proposed for coverage been diagnosed as having, been treated for or, had care for which diagnostic test(s) have been recommended for: Cancer, (including hodgkin's disease, lymphoma, leukemia, melanoma or any other malignancy) other than Skin Cancer? If "yes", list name of person(s) _____ **who is/are to be excluded from coverage.**	☐ Yes ☐ No
3.	Within the past three years, has any person proposed for insurance been diagnosed as having, been treated for or, had care for which diagnostic test(s) have been recommended for Skin Cancer? If "yes", name of person(s) _____ **who is/are to be excluded from coverage for cancer of the skin.**	☐ Yes ☐ No

LN-6049-AR

***FOBB can only be purchased if FOB is also purchased.**

CONTINUED ON PAGE 2

MEDICAL QUESTIONNAIRE

4.	Has anyone proposed for coverage ever been diagnosed as having or treated by a member of the medical profession for: Acquired Immune Deficiency Syndrome (AIDS), "AIDS" Related Complex (ARC), or a condition or sickness derived from such infection, or tested positive for the Human Immuno-deficiency Virus (HIV) infection? If "Yes", list name of person(s)_____ **who is/are to be excluded from coverage**.	☐ Yes ☐ No
If Optional Specified Disease Rider is Applied for, Answer this Question.		
5.	Within the past five years, has any person proposed for coverage been diagnosed as having, been treated for, or had care for which diagnostic test(s) have been recommended for: Addison's Disease; Amyotrophic Lateral Sclerosis; Botulism; Bovine Spongiform Encephalopathy; Budd-Chiari Syndrome; Cystic Fibrosis; Diptheria; Encephalitis; Epilepsy; Hansen's Disease; Histoplasmosis; Legionaire's Disease; Lupus Erythematosus; Lyme Disease; Malaria; Meningitis; Multiple Sclerosis; Muscular Dystrophy; Myasthenia Gravis; Nieman-Pick Disease; Osteomyelitis; Poliomyelitis; Q Fever; Rabies; Reye's Syndrome; Rheumatic Fever; Rocky Mountain Spotted Fever; Sickle Cell Anemia; Tay-Sachs Disease; Tetanus; Toxic Epidermal Necrolysis; Tuberculosis; Tularemia; Typhoid Fever; Undulant Fever; West Nile Virus; Whipple's Disease or Whooping Cough? If "yes", list name of person(s) and Specified Disease:_____ **who is/are to be excluded from coverage for the listed Specified Disease.**	☐ Yes ☐ No
If Optional Intensive Care Unit Rider is Applied for, Answer this Question.		
6.	Has any person to be insured ever been diagnosed or treated for a heart attack, heart condition, heart trouble, angina or any abnormality of the heart prior to this date? If "yes", name of person_____ **who is to be excluded from coverage for any intensive care confinement resulting from any disorder of the heart and shall be limited to three days in connection with any other intensive care confinement.** **The person(s) named above will be excluded from coverage as follows:** We will not be liable for any loss for Hospital Intensive Care Unit confinement resulting from any disease or disorder of the heart. Furthermore, the benefits for such person(s) for confinement in a Hospital Intensive Care Unit will be limited to three days in connection with any one hospitalization for all other sickness, not the 45 days as stated in the Rider. Nothing herein shall affect benefits for any covered Hospital Intensive Care Unit confinement resulting from an Injury.	☐ Yes ☐ No

NON-MEDICAL QUESTIONNAIRE

1.	Is any proposed insured eligible for Medicare? If "yes" review the Guide to Health Insurance for People with Medicare which is available from the company.	☐ Yes ☐ No
2.	Is any proposed insured eligible for Medicaid? **(If "Yes" applying for coverage on that person is not appropriate.)**	☐ Yes ☐ No
3.	**Existing Insurance**. Is any proposed insured covered under major medical insurance or an HMO? If "Yes", list name of proposed insured, coverage type, and insurance company.	☐ Yes ☐ No
4.	**Replacement.** Is the insurance applied for to replace or change any existing insurance? If "Yes" list coverage and name of company._____ and complete any required replacement form(s) provided by your agent and return with this application.	☐ Yes ☐ No
5.	Have you received any required Outline of Coverage?	☐ Yes ☐ No

AGREEMENT: I have read or had read to me the completed application form and any supplement, and my statements and answers are true and complete, to the best of my knowledge and belief. I understand that any material misstatement or misrepresentation may result in loss of coverage. I understand that the effective date of the coverage will be the date stated on the Policy's schedule page, not the date this application form is signed. I understand that no agent can accept risks, modify policies, or waive any rights or requirements of LifeShield National.

Signature of Applicant: X _____ **Date:** _____

Affidavit for Agent's Use Only: I hereby certify that I have truly recorded in this application the information supplied by the applicant. I also certify that the applicant has read or had read to him or her the completed application.

Licensed Resident Agent's Signature _____ Licensed Resident Agent's No. _____

Agent's Name: (please print) _____ State License No _____

Authorization and Request for Payroll Deductions

I have applied for Cancer insurance with LifeShield National Insurance Company and I hereby authorize and request that you, my employer, deduct from my salary or wages the necessary amounts to pay the premiums for this insurance and forward it to LifeShield National. If premiums for the insurance to which this authorization applies are part of a Cafeteria Plan, I understand that this authorization may not be revoked until the end of the Plan Year and only then by my written request. Otherwise, this authorization shall remain in effect until revoked in writing by me.

Per Pay Period Initial Premium Amount:$_____ Employer:_____

_____ _____ _____

Employee Signature | Social Security or Employee Number | Date

LifeShield National Insurance Company®
Administrative Office: 815 West Ash Ave., Duncan, OK 73533 Toll Free: 1-800-366-8354
Application Form for Cancer Insurance and Optional Riders

NONPAYROLL APPLICATION FORM

Employer		Group Number	Billing Mode ☐ M PAC ☐ Q ☐ SA ☐ A ☐ Other_____	
Applicant Proposed for Insurance (First, MI, Last)		S. S. Number	Employee Number	
☐ Emp ☐ Spouse ☐ Child ☐ Other	☐ Male ☐ Female	Age	Birth Date	Home Phone Number
Home Address		City	State	Zip
Job Title/Occupation	Do you normally work 20 or more hours per week for the Employer listed above? ☐ Yes ☐ No		State of Birth	Date Hired
☐ Payor or ☐ Owner (if other than Proposed Insured) & Address		S.S. Number or Tax ID Number	Birth Date	

DEPENDENTS PROPOSED FOR INSURANCE

	Full Name	Sex		Birth Date
Spouse		☐ M	☐ F	
Children		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	
		☐ M	☐ F	

INSURANCE APPLIED FOR

Cancer Insurance (Includes Base Policy)	ASCB	FOB	FOBB*	RCIB required	SB	DHCB	SDB	ICUB	Modal Premium
☐ Individual ☐ One Parent ☐ Family	$_____ Per year	$_____ Lifetime maximum	$_____ Per year	$ ☐ Annual ☐ Daily	$_____ Per schedule	$_____ Per day	$_____ Per day	$_____ Per day	$

MEDICAL QUESTIONNAIRE

1.	Within the past ten years, has any person proposed for coverage been diagnosed as having, been treated for, or had care for which diagnostic test(s) have been recommended for: Cancer, (including hodgkin's disease, lymphoma, leukemia, melanoma or any other malignancy) other than Skin Cancer? If "yes", list name of person(s) _____ **who is/are to be excluded from coverage.**	☐ Yes ☐ No
2.	Within the past five years, has any person proposed for insurance been diagnosed as having, been treated for, or had care for which diagnostic test(s) have been recommended for Skin Cancer? If "yes", name of person(s) _____ **who is/are to be excluded from coverage for cancer of the skin.**	☐ Yes ☐ No

***FOBB can only be purchased if FOB is also purchased.**

LN-6050-AR

CONTINUED ON PAGE 2

	MEDICAL QUESTIONNAIRE	
3.	Has anyone proposed for coverage ever been diagnosed as having or treated by a member of the medical profession for: Acquired Immune Deficiency Syndrome (AIDS), "AIDS" Related Complex (ARC), or a condition or sickness derived from such infection, or tested positive for the Human Immuno-deficiency Virus (HIV) infection? If "Yes", list name of person(s) _____ **who is/are to be excluded from coverage.**	☐ Yes ☐ No
If Optional Specified Disease Rider is Applied for, Answer this Question.		
4.	Within the past ten years, has any person proposed for coverage been diagnosed as having, been treated for, or had care for which diagnostic test(s) have been recommended for: Addison's Disease; Amyotrophic Lateral Sclerosis; Botulism; Bovine Spongiform Encephalopathy; Budd-Chiari Syndrome; Cystic Fibrosis; Diptheria; Encephalitis; Epilepsy; Hansen's Disease; Histoplasmosis; Legionaire's Disease; Lupus Erythematosus; Lyme Disease; Malaria; Meningitis; Multiple Sclerosis; Muscular Dystrophy; Myasthenia Gravis; Nieman-Pick Disease; Osteomyelitis; Poliomyelitis; Q Fever; Rabies; Reye's Syndrome; Rheumatic Fever; Rocky Mountain Spotted Fever; Sickle Cell Anemia; Tay-Sachs Disease; Tetanus; Toxic Epidermal Necrolysis; Tuberculosis; Tularemia; Typhoid Fever; Undulant Fever; West Nile Virus; Whipple's Disease or Whooping Cough? If "yes", list name of person(s) and Specified Disease:_____ **who is/are to be excluded from coverage for the listed Specified Disease.**	☐ Yes ☐ No
If Optional Intensive Care Rider is Applied for, Answer this Question.		
5.	Has any person to be insured ever been diagnosed or treated for a heart attack, heart condition, heart trouble, angina or any abnormality of the heart prior to this date? If "yes", name of person _____ **who is to be excluded from coverage.**	☐ Yes ☐ No
	NON-MEDICAL QUESTIONNAIRE	
1.	Is any proposed insured eligible for Medicare? If "yes" review the Guide to Health Insurance for People with Medicare which is available from the company.	☐ Yes ☐ No
2.	Is any proposed insured eligible for Medicaid? **(If "Yes" applying for coverage on that person is not appropriate.)**	☐ Yes ☐ No
3.	**Existing Insurance**. Is any proposed insured covered under major medical insurance or an HMO? If "Yes", list name of proposed insured, coverage type, and insurance company.	☐ Yes ☐ No
4.	**Replacement.** Is the insurance applied for to replace or change any existing insurance? If "Yes" list coverage and name of company._____ and complete any required replacement form(s) provided by your agent and return with this application.	☐ Yes ☐ No
5.	Have you received any required Outline of Coverage?	☐ Yes ☐ No

AGREEMENT: I have read or had read to me the completed application form and any supplement, and my statements and answers are true and complete, to the best of my knowledge and belief. I understand that any material misstatement or misrepresentation may result in loss of coverage. I understand that the effective date of the coverage will be the date stated on the Policy's schedule page, not the date this application form is signed. I understand that no agent can accept risks, modify policies, or waive any rights or requirements of LifeShield National.

Signature of Applicant: X _____ **Date:** _____

Affidavit for Agent's Use Only: I hereby certify that I have truly recorded in this application the information supplied by the applicant. I also certify that the applicant has read or had read to him or her the completed application.

Licensed Resident Agent's Signature _____ Licensed Resident Agent's No. _____

Agent's Name: (please print) _____ State License No. _____

RECEIPT

ALL PREMIUM CHECKS MUST BE PAYABLE TO "LifeShield National Insurance Company"

DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK

Received from _____ an application for Cancer Insurance and the sum of $_____ for _____ month's premium. The effective date of the coverage will be the date stated on the Policy's schedule page, not the date of this receipt. If the policy applied for is not issued within 60 days, the amount paid will be refunded.

Agent's Signature _____ Agent's Telephone Number _____ Date _____

Agent's Address: _____ City: _____ St_____ Zip_____

If you have not received a policy or a refund of premium within 60 days of the date of this receipt, contact LifeShield National Insurance Company

Administrative Office: 815 West Ash Ave., Duncan, OK 73533 Toll Free: 1-800-366-8354